# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

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|---|---|
| Organization* (if applicable): | Alameda County Sheriff's Office, Youth & Family Services Bureau |
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**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

X Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

X Disparities in Access to Mental Health Services
X Psycho-Social Impact of Trauma
X At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

❒ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
❒ Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

***Mental Health Services Act***
***Prevention & Early Intervention***

**Community Report Executive Summary**

## I. Organization Background

The Youth and Family Services Bureau (YFSB) was formed in 2001 within the Alameda County Sheriff's Office. Its overarching goal is to address the problems of at-risk youth who are incorrigible, runaway, truant, first-time offenders, or exhibiting potential gang affiliations, and to provide counseling and support services, information and referral, case management, and crisis intervention services intended to address the underlying issues causing these dangerous and unacceptable behaviors. The YFSB receives an average of 350-400 referrals annually from law enforcement personnel, school staff, local social service and child welfare agencies, and concerned family or community members. The goal of the YFSB, through a prevention and early intervention model, is to serve as a dedicated community resource to increase the safety, success, and well being of children and their families, schools, and community. The YFSB has established working partnerships with the San Lorenzo, Castro Valley, and Dublin Unified School Districts, serving on School Attendance Review Boards where truancy cases are addressed and providing counseling and other related services to District students and families, and consultation to District educators and administrators.

YFSB also provides diversion counseling to keep middle school and high school youth out of the juvenile justice system when they have received a "Notice to Appear" from law enforcement for non-felony misdemeanors on school grounds or during the school day. These misdemeanors range from intoxication or possession of illegal substances to fighting and petty theft.

## II. Data Sources

- 2000 Census
- 2005 National Gang Threat Assessment
- May 2006, Ashland-Cherryland Youth Collaborative, Violence Prevention Survey of students and parents in the San Lorenzo Unified School District
- Herrera, C., Sipe, C.L., and McClanahan, W.S., Mentoring School-Age Children: Relationship Development in Community-Based and School-Based Programs, April 2000, prepared for the National Mentoring Partnership's Public Policy Council

## III. Recommendations

The recommendation we are making today is for the development of a replicable pilot program of mentoring at risk school age youth in the San Lorenzo School District in South County. This program would address children who are at risk for school failure due to exposure to multiple family pressures, including drug addiction, unemployment, cultural and language barriers due to recent immigration, the lack of broad availability of

safe after-school activities and the consequent exposure to gang affiliation. Mentors would be MFT interns hired for this purpose and also recruited from School Resource Officers who are certified law enforcement personnel currently assigned to individual schools. They are trained not only to function as law enforcement officers, but as school-based, law-related counselors and educators.

We are anticipating the following outcomes from the development of this mentoring pilot.

Individual/Family Outcomes:

- Reduced truancy, decreased juvenile crime, and increased academic success.
- Enhanced stability and trust resulting in few or no disciplinary actions.
- Increased family cohesion.

Program & System Outcomes:

- Development and proof of a replicable model for other school districts that addresses and remediates significant causes of school failure.

Long-Term Community Outcomes:

- Reduced school failures on the part of at risk youth.
- Reduced gang activity and recruitment of youth.
- Development of positive connections between families, schools and law enforcement.

**Community Report:**
**Developing a Mentor Model in a Local School District**

## I. Scope of the Problem

Recently, an Alameda County Deputy Sheriff met with a Joseph*, a twelve year-old fifth grader at Lorenzo Manor Elementary School in San Lorenzo, California after the boy was found to be tagging his school papers, backpack, and the walls of the boys' restroom with gang-related graffiti. The boy reluctantly admitted that, following in the path of several brothers and older cousins, he was already affiliated with the local gang whose signs he was perpetuating. Joseph was asked if he had any dreams or ambitions in life, or if he intended to grow up to be a thug and a gangster. After reflecting for a moment, he replied in a very sincere manner, "I really believe the gang life is the track I'm on right now." The tone of his answer suggested that, to the boy at least, such a life "track" was practical and accessible. Ten year-old Marissa and her seven year-old brother Tony* attend Colonial Acres Elementary School, also in San Lorenzo. The school is preparing to expel Marissa due to increasingly disruptive and defiant behavior in the classroom and with her peers, which recently culminated in Marissa flashing a pocket knife at a schoolmate who was teasing her little brother and threatening, "I'll cut you if you don't leave him alone." Marissa was referred to the Youth and Family Services Bureau, a counseling unit within the Alameda County Sheriff's Office. There it emerged that, after fleeing with her children from their home in Sacramento, California to escape her abusive husband, Marissa and Tony's mother has become addicted to methamphetamines and currently spends days on end either absent from the home or

*Names and identifying information have been changed to protect confidentiality

sleeping around the clock as she “comes down,” leaving the care of the younger children to Marissa and her thirteen year-old sister, Bethany. Bethany was recently arrested for shoplifting cereal and Kraft “Lunchables” from Target, because there was nothing to eat in the house.

These children, and thousands of others facing similar challenges, live in the unincorporated areas of Alameda County such as parts of Hayward and San Leandro, San Lorenzo, Ashland, and Cherryland that are served by the Alameda County Sheriff’s Office. These are ethnically and culturally diverse, low-income areas with a high incidence of gang activity and youth crime. Over the past decade, Ashland/Cherryland has experienced a population increase of 24%. At the time of the 2000 Census, the population was 35% Latino, 31% White, 16% African American, 13% Asian and Pacific Islander, 4% reported two or more races, and less than 1% Native American. Children under 14 made up 24% of the population, compared with 21% in Alameda County as a whole. 40% of households in the area earned incomes of under $30,000 in 1999, compared with 28% in Alameda County as a whole, and 15% of children were enrolled in CalWORKS/public assistance, versus 10.8% countywide. 29% of residents over 25 lacked a high school diploma, versus 18% in Alameda County as a whole. From 1997 to 1999, the teen birth rate at 58.8% per 1000 girls ages 15 to 17, was more than twice the County rate of 24.7 per 1,000. As of December 1999, 10.6% of 1,000 children were confirmed as abused or neglected, versus the overall county rate of 6 per 1,000. The median rate of injury hospitalization in 1996-98 across the area’s 3 zip codes was 666 per

100,000 total population as compared to Alameda County's total rate of 553 per 100,000. 19% of those injury hospitalizations in the 15-34 year old age group were due to assault.

As these statistics strongly suggest, children in this area face significant challenges to their health, safety, and education, and overall future prospects. Many inhabitants are historically at-risk and underserved and are struggling with intergenerational legacies of poverty, under-education, under-employment and unemployment, abuse, chemical dependency, incarceration, medical indigence, and language and transportation barriers that make accessing scant resources difficult. There is also a high incidence of families headed by first generation immigrants unfamiliar with American educational, political, commercial, social service, and law enforcement infrastructures, further limiting their ability to position their families to thrive in a challenging urban environment. Educational, cultural, and recreational activities for children in the area are few, especially for children of low-income and single parent families. Consequently, many of these children spend their time congregating on city streets and many become involved in gangs and juvenile street crime.

Within these communities, there is growing cause for concern about the escalating extent of this youth involvement. According to the 2005 National Gang Threat Assessment, 143 law enforcement agencies within the overall Western region reported significant increases in gang-related activities such as vandalism, assault, firearm possession, drug trafficking, auto theft, burglary, and homicide. Within the jurisdiction of the Sheriff's Office, the presence of such gangs as Los Surenos, Nortenos, the Mexican Mafia, Asian and South Pacific Islander groups, as well as smaller neighborhood gangs, is on the rise. As in the case of Joseph above, children are joining gangs at younger and

younger ages. First and second grade elementary school students have been observed "throwing" the signs of the local gangs.

In May 2006, the non-profit Ashland-Cherryland Youth Collaborative conducted a Violence Prevention Survey of students and parents in the San Lorenzo Unified School District. Almost one-third of the 120 adults and 434 students surveyed answered no to the question, "In general, do you feel that your community is a safe place to live?" Equally as instructive were the comments provided by those surveyed when asked what they would do to make things better. Not only a greater police presence, but also increased after-school and enrichment opportunities for youth were requested to foster a greater sense of community as well as to provide character development, opportunities for the development of academic, athletic, and artistic potential, and general emotional support and guidance for our embattled local youth.

In its comprehensive study of child mentoring, Public/Private Ventures presents school-based mentoring as a highly promising modality due to its relative cost-effectiveness, the tendency for a less intensive time commitment from volunteers, and the potential to significantly impact the child's academic performance (Herrera, C., Sipe, C.L., and McClanahan, W.S., Mentoring School-Age Children: Relationship Development in Community-Based and School-Based Programs, April 2000, prepared for the National Mentoring Partnership's Public Policy Council). Through the schools, children at the greatest risk can be identified by "red flag" markers such as academic, disciplinary, and attendance problems, as well as by observations and recommendations from teachers, school counselors, and administrators. By the fourth and fifth grades, students with significant underlying and unmet multi-layered needs are more readily

identifiable as critical academic and behavioral deficits emerge. The same research also suggests that elementary age children are more likely to develop closer, more supportive relationships with mentors than adolescents (Herrera, Sipe, and McClanahan, ibid). School-based mentoring intervention is a valuable resource to address these deficits and stabilize children in preparation for the academic, emotional, physiological, and social challenges of adolescence and the transition, often rocky even under the best of circumstances, to middle school and beyond.

## II. Target Population for Mentoring Services

In response both to the increasingly urgent perceived, expressed, and documented need within our community for increased youth resources, as well as to current research and methodology that delineate the tremendous potential benefits of mentoring programs to high risk youth, the Alameda County Deputy Sheriffs' Activities League, Inc. (DSAL) has joined in informal collaboration with the Sheriff's Office Youth and Family Services Bureau and the San Lorenzo Unified School District to develop a model mentoring program and seek funding.

The children identified by the San Lorenzo Unified School District as having the greatest unserved need for mentoring programs are the fourth and fifth grade students at Bay, Colonial Acres, Del Rey, Grant, and Lorenzo Manor Elementary Schools. Bay had 501 enrolled students in the 2006-2007 academic year, Colonial Acres had 552, Del Rey 510, Grant 409, and Lorenzo Manor, 590. There are currently a total of 461 fourth graders and 405 fifth graders between the five schools, or 866 fourth and fifth graders. A median of 55% of pupils were enrolled in Limited English Proficiency (LEP)

programming. A median of 46.15 % of elementary pupils qualify for the free/reduced lunch program due to low household income, providing strong evidence of socioeconomic stress and reduced opportunity within the student body. During the 2005-2006 academic year, 61 fourth and fifth graders received disciplinary suspensions and 31 were identified as having significant truancy issues which resulted in School Attendance Review Team meetings, or formal responses to serious, unresponsive school truancy. This data furthers the picture of a struggling student population with critical academic and behavioral deficits stemming from serious underlying and unmet multi-layered needs. In response to DSAL queries about how many fourth and fifth grade children the District would refer for mentoring services, District Director of Special Services Angelo Madrigal informed the DSAL at least thirty-five to forty percent, or approximately 324 children, would benefit from the guidance of a mentor.

## III. Program Design

The full Mentoring Program as proposed through this inter-agency collaboration of local programs serving youth would be designed as follows:

New funding would be used to hire ten part-time Mentor Coordinators, who will be post-Masters Registered Marriage and Family Therapist Interns. These Mentor Coordinators will be supervised by a Program Director, who will be a licensed Marriage and Family Therapist, and they will work primarily on-site at the five identified Elementary Schools. Two Mentor Coordinators will be posted to each school and will remain at the same site for the duration of the program to cultivate the familiarity, comfort level, and communication between the school staff and children and their

assigned Mentor Coordinators. Students to be offered mentoring services will be identified by means of communication and consultation between Mentor Coordinators, classroom teachers; school administration, counseling, and resource staff; and School Resource Officers. Children who have been formally identified by school attendance and disciplinary interventions such as the “SART” (School Attendance Review Team), “SARB” (School Attendance Review Board), suspensions, and recommended expulsions will take precedence in the referral process, as well as children whose classroom teachers have observed to be struggling with academic, emotional, or circumstantial difficulties. Referred children will receive a comprehensive assessment including school academic, disciplinary, and attendance records; mental health and emotional status; medical and developmental history, including any documented incidents of child abuse; criminal and/or gang participation history (if any); family, social, and community life; substance abuse and/or sexual history (if any); cultural, ethnic, and spiritual affiliations; individual talents, temperament, and interests; and stated hopes and goals for the future.

Based upon the results of this assessment, Mentor Coordinators will design a custom, multi-level program for each participant. First, each participant will be assigned an individual mentor. Children will meet with their mentor for on one-on-one mentoring support on at least a weekly basis, although more time spent will be encouraged and facilitated. Mentoring relationships will be encouraged to persist well beyond a minimum twelve-month period. In fact, the option of mentoring relationships persisting past the end of the grant period will be presented and supported as the ideal, with the mutual benefits to both parties in the dyad elucidated.

In addition to one-on-one mentoring relationships, the program will also provide periodic group activities for program participants in which cultural and educational opportunities are provided that children might not otherwise have a chance to experience. Such opportunities will include attending museums, science centers, nature walks, and events such as ethnic festivals and music, dance, and theatrical performances. Every effort will be made to plan and select activities and events that are age appropriate, culturally diverse, and that in various ways foster and inspire the growth of values such as curiosity, creativity, compassion, awareness, and personal integrity. In order to foster a positive relationship with the school they attend, participants will also engage in scheduled school site service activities such as playground cleanup and mural making. To encourage a broader sense of community mindedness and the joys and satisfactions of "giving back," children will also contribute to age appropriate service activities such as visits to senior centers, holiday toy drives, and packing groceries for the homeless at the local food bank.

Beyond the scope of planned group activities, Mentor Coordinators will also include recommendations and referrals for participants to engage in supplementary enrichment activities and services beyond the one-on-one scope of the basic mentoring dyad. These referrals might range from academic tutoring and homework assistance; to planning for career, job training, and higher education goals; to athletic and cultural clubs, leagues, and lessons; to professional counseling and social service assistance to the mentored youth and/or family members on an as needed basis. For example, through the DSAL, a range of constructive, free after-school cultural, recreational, and athletic programs are always available. At identified Elementary Schools, the San Leandro Boys

and Girls Clubs are now providing no or low-cost after school academic assistance. Children who might not on their own initiative attend much needed academic tutoring or homework clubs will be more likely to do so if they are encouraged to attend, or are accompanied by, their mentor. Through the Youth and Family Services Bureau, mental health services will be made available as needed to participants and their relatives at no charge. Since the YFSB mental health unit is already running at full capacity, new funding will be needed to hire an additional Youth and Family Services Therapist due to the anticipated increase in the volume of mental health service needs. Throughout the course of the program, children will be encouraged to explore and develop their own personal strengths, values, opinions, and interests, and guided to consider, on a level of practical decision-making, how their future educational and career choices might be directed to best utilize these qualities. Because the Mentor Coordinator and participant will meet weekly, there will be opportunity for facilitation, follow-up, encouragement, practical support, and program adjustment in order to best support both ongoing and changing needs of participants as well as ensuring continuing progress in developing the unique potential of each child who is a part of the program.

Close attention will be paid to all levels of project management, including mentor recruitment, screening, orientation, training, support, and mentor/participant matching and monitoring. Mentors will be recruited from a variety of sources: within the schools, the Sheriff's Office, and the broader community. In 2005, the San Lorenzo Unified School District created the Future Academy, a college preparatory, small learning community located at Arroyo High School. The Academy is attended by approximately 300 ninth through twelfth graders and is designed to encourage students to learn about

themselves and their communities through an integrated curriculum, internships within the community, and a focus on making the world a better place through community involvement and service. The informational brochure provided by the Academy states, “the greatest learning happens not by seeing but by doing. Future students learn through projects, internships, field trips, and mentor relationships with professionals in the community.” District officials are excited about, and supportive of, the potential opportunity for Future Academy students, through the proposed mentoring program, to serve as mentors themselves to needy younger children in their own community. High school age mentors would be recruited from this group, as well as from San Lorenzo’s three mainstream high schools, Arroyo, San Lorenzo, and East Bay Arts, based on teacher recommendations, excellent academic, disciplinary, and attendance records, and a clear criminal history check. High school students would also be motivated to serve by the opportunity to obtain academic credit for playing sustained mentoring roles with program participants.

Mentors will also be recruited among School Resource Officers and other law enforcement personnel employed by the Sheriff’s Office. Eight out of the eight School Resource Officers posted at local schools have already expressed a desire to serve as individual mentors if and when grant funds are obtained. School Resource Officers are certified law enforcement officers who are permanently assigned to certain schools within the jurisdiction. They are trained not only to function as law enforcement officers, but as school-based, law-related counselors and educators. Typical duties include the prevention of juvenile delinquency through close contact with students and school personnel, acting as a liaison between principals, faculty, students, and security

personnel, providing liaison between students and needed social agencies and program, and participating in campus activities, student organizations, athletic events, and PTA meetings, as needed and invited. Given their ongoing contact and familiarity with the educational community, School Resource Officers are ideally situated to serve in a one on one mentoring capacity, which will also serve the additional function of improving the image of law enforcement officers and agencies within the community. Mentors will also be drawn from concerned community members. The Program Director and Mentor Coordinators will conduct ongoing outreach at local town halls, Citizen's Academies, homeowner association meetings, senior centers, Sheriff's Advisory Board meetings, faith-based institutions, and other local venues.

The proposed mentoring program will strive to recruit and retain effective mentors through a variety of "best practice" approaches. In the recruitment process, candidates will be motivated by tailoring the benefits of becoming a mentor to the group being recruited. For instance, high school students will be made aware of the career and academic benefits of participation as mentors, while senior adults will be appealed to through the opportunities to transmit values and life experience while contributing to the well-being of their community (Okun, M.A., and Schultz, A. (2003) "Age and Motives for Volunteering: Testing Hypotheses Derived From Socioemotional Selectivity Theory," Psychology and Aging, 18, 231-239). The program design will also reflect state of the art findings on mentor retention, such as providing mentors with information on realistic expectations of the rewards and challenges of mentoring (Stukas, A.A., Snyder, M., and Clary, E.G. (1999). "The Effects of "Mandatory Volunteerism" On Intentions to Volunteer," Psychological Science, 10(1), 59-64); educating mentors on the adverse

impact of mentor withdrawal from a mentoring dyad (Grossman, J.B., and Rhodes, J.E., "The Test of Time, Predictors and Effects of Duration in Youth Mentoring Relationships," American Journal of Community Psychology, 30, 199-219); and providing substantial ongoing training and support to foster the growth of positive internalized identity as a youth mentor within each volunteer. Generally, the program design will provide the ongoing support, communication, and recognition that will help volunteer mentors feel the kind of connection to the program purpose, the staff, and participants that will sustain over time. Mentors will also be recognized regularly not only through verbal but also concrete acknowledgement and appreciation such as certificates and celebratory events. An annual summit will also be held for mentors and program participants to convene, connect, and celebrate individual and group successes, and to consolidate the identity of the program as a whole.

Close attention will also be paid to the mentor/child matching process and driven by the underlying awareness that a carefully made match will be much more likely to succeed over time. The longevity of a mentor match has great potential benefits. According to one study, children in a mentor relationship that endured over 12 months have been found to have significantly higher levels of self-worth, social acceptance, and scholastic competence, reported improved relationships with parents, enjoyed school more, and reported declining drug and alcohol usage. (Grossman and Rhodes, ibid). In the matching process, an essential initial step will be to ask mentors and children themselves about their preferences and ideas with regard to the type of match they envision. The results of the comprehensive child assessment conducted at the entry of participants into the program will be incorporated, as will information and impressions

gathered during the mentor recruitment and screening process. Referring teachers, counselors, and school staff who are familiar with program participants will be asked for their ideas and recommendations with regard to the matching process. Demographic and personal information on both individuals within each potential dyad will be factored in such as age, gender, ethnicity, socio-economic background and status, hobbies and interests, available times, personality and temperament, religious or spiritual identity, developmental, academic, and emotional needs of the child, profession of mentor/career goals of child (if any), second language capacity of mentor, and so forth in order to determine a compatible match that has a high likelihood of durability and success. It will not be assumed that individuals who are merely similar in general demographic aspects will be necessarily be the most compatible match, although in some cases, they might, but rather a more complex and multi-layered process of analyzing and anticipating the needs, qualities, and potential of each mentor-child relationship will be attempted.

State of the art research in the field leaves no room for doubt on the benefits of mentoring for children. According to an article by J.G. Dryfoos, "The Role of the School in Children's Out-Of-School Time: Involvement of Adult Mentors," The Picture of Children, Fall 1999 9(2):110), the involvement of an adult mentor in a young person's life for just one year decreased first-time drug use by 46% and cut school absenteeism by 52%. In her 2004 study of youth mentoring, which summarizes ten years of research through the Big Brothers and Big Sisters organization, clinical psychologist Jean Rhodes presents a compelling picture of the way in which within an optimal mentoring dyad, mentors can greatly support at-risk children in three important ways: enhancing their social skills, improving the cognitive skills through dialogue and

listening, and serving as a role model and advocate (Stand By Me: the Risks and Rewards of Mentoring Today's Youth, Harvard University Press, 2004). Furthermore, the proposed project design incorporates key features of the most effective mentoring programs found across various research studies on the topic: the fostering of close and supportive mentoring relationships; high quality mentor training; structured activities for mentors and youth; clear expectations about frequency of contact; and monitoring of overall program implementation (Dubois, D.L., Holloway, B.E., Cooper, H., and Valentine, J.C., "Effectiveness of Mentoring Programs for Youth: a Meta-Analytical Review, " American Journal of Community Psychology (in press); Sipe, C.L., "Mentoring: a Synthesis of P/PV's Research: 1988-1995" (PDF, 368KB). (Philadelphia: Public/Private Ventures, 1996).

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*Under each category, choose the item your report PRIMARILY addresses:*

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X Underserved Cultural Populations
Individuals Experiencing Onset of Serious Psychiatric Illness
X X Children/Youth in Stressed Families
X Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement

# COMMUNITY REPORT EXECUTIVE SUMMARY

SECTION I - ORGANIZATIONAL BACKGROUND:

Center for the Vulnerable Child (CVC) was established in 1986 as a department within Children's Hospital & Research Center Oakland (CHRCO) to address child abuse/neglect and family substance abuse and their impact on the health, mental health and development of young children living in urban poverty. The CVC's mission is to promote the health and social welfare of vulnerable children and their families through a range of flexible services that include case management, mental health and developmental assessments, child and family therapy, parent education and support. CVC's approach is preventative and family-focused. CVC's services are funded through a combination of federal, county, and private grants and contracts.

CVC's target population consists of children who are homeless or at risk of homelessness, or who live in foster care families. We currently serve over 2100 children birth to nineteen years and their families. Most children are ethnic/racial minorities, primary African American and Latino. These children often have traumatic experiences. Many have lived in shelters and in transitional environments and others have been part of the child welfare system. Unfortunately, family substance abuse plays a part in these children's lives. Clearly, these children are at very high risk for mental health, school and behavioral problems.

Current CVC programs include: 1) SEED, Services to Enhance Early Development, a collaborative project between Alameda County's Department of Children & Family Services (DCFS) and the CVC, which serves children, birth to three years of age and who are in the child welfare system; 2) CORE (Case Management Outreach, Referrals & Education) which works to improve conditions that place children and families at social or psychological risk; 3) CATS (Child Assessment and Transition Services), for children and families who receiving child welfare services when children are not removed from their biological families; 4) Project SPARK, providing on-site one-to-one interventions at Head Start and Child Development Centers to children and consultation to staff. 5) PASSAGE, crisis assessment and case management services for children whose foster care placements are failing and who need immediate services. 6) Foster Parent Education and Support Groups, twice-monthly groups open to Alameda County foster parents. 7) The FOSC and ENCORE, Ambulatory Clinics for children who either have had contact with the child welfare system, have been homeless, or both, providing specialized primary care by pediatricians and case managers.

Our services are home and center-based and provided by a multidisciplinary clinical team of 30 case managers, social workers, child development specialists, psychologists, and child and family counselors. For the past year CVC has been engaged in a strategic planning process focussed on improving our cultural responsiveness and accountability to the community of clients that we serve. We will continue to improve our ability to serve the diverse clients in the community and to provide more effective mental health services.

CVC and Alameda County's DCFS have been working together, with an overlapping population of children, since its inception. CVC also has developed relationships with a variety of agencies that serve homeless children and families in Alameda County including Alameda County's Housing Authority. Finally, we have developed a relationship with Oakland Unified School District, Child Development Centers and Head Starts in Oakland and Alameda and are providing training, consultation, and intensive one-to-one work with selected children in their classrooms. CVC staff participate in several state and county policy groups: Northern California Foster Care Task Force, Alameda County SART Task Force, Alameda County Early Childhood Mental Health Policy Group, Alameda County EPSDT Steering Committee, and the Alameda County Foster Parent Advisory Committee.

SECTION II - DATA SOURCES:

Information for this report was gathered through interviews and conversations with CVC service providers and was based on our many years of experience serving children. These children often live in communities and families that have high levels of violence, instability and disruption. The recommendations contained in this report who obtained from providers at CVC's various program clinical/staff meetings. These recommendations reflect the wisdom, expertise, and experience of our service providers many of whom have been with the CVC for 10 years or more.

SECTION III - RECOMMENDATIONS:

A Community-Based Program to Increase Safety & Reduce Isolation

We believe that the solutions for preventing trauma resulting from violence that is so endemic in our communities must emanate from the communities themselves in order to be relevant, effective, and enduring. The mental health, behavioral, and school related difficulties that require earlier intervention and prevention services are complex, have multiple layers, and are interconnected. Violence in children's neighborhoods, instability and substance abuse, a pervasive lack of access to and trust in supportive services are just some of the underlying realities that contribute to difficulties in these children's lives. To address and understand these "problems" as simply residing in the children themselves will lead to interventions that will not, in the long run, make the sustainable changes we all would want for them.

The CVC's recommendation for use of funds from MHSA is to create a pilot program that uses a strength-based approach that will mine the riches and strengths of a specific community. The goal is to develop and implement a plan with the overarching vision of increasing safety and reducing isolation in that community. The results of such an innovative approach would be to (1) decrease the conditions that are the powerful negative contributors of violence and trauma; and (2) increase the services and supports identified specifically in that community to address the needs of children and families. The *process* of development and implementing such a pilot program would be the heart and soul of producing positive changes and community healing. We envision bringing together people from the community of all ages including teens and elders. We also envision the development of resources through schools, the police, churches, recovery programs, parent advocates, and community partners.

The steps in this multi-year pilot project would be:

- A neighborhood or catchment area would be selected with an elementary school or community center at its center.
- A guided strategic planning process would be supported to gather people and begin a conversation that would address issues and service needs specific to that community.
- Development of a community needs assessment to identify services and supports already existing and those that are missing.
- Strengthening and supporting those services and community resources already in place.
- Implementation of new prevention/early intervention strategies as identified by the community.
- Evaluation was not only incorporate basic process and outcome measures, but also measure community input and participation.

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Phone No./ Email address (510) 758-7077; dbrown247@yahoo.com

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

☑ Children & Youth (0-18) ☑ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

☑ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
☑ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

☑ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
☑ Children/Youth in Stressed Families
☑ Trauma-Exposed
☑ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

# CHILDREN AND FAMILY SERVICES NETWORK OF ALAMEDA COUNTY
# PREVENTION AND EARLY INTERVENTION RECOMMENDATIONS
# EXECUTIVE SUMMARY

SECTION I - ORGANIZATIONAL BACKGROUND: The Children and Family Services Network of Alameda County (CFSN) was founded a year and a half ago by 10 of the leading agencies serving vulnerable children, youth and their families in Alameda County. The network has grown to include more than 25 private and non-profit providers who are fully committed to helping all children and youth get the best possible start in life and to be equipped with the skills, knowledge and support needed to succeed as adults (see attached list of members).

CFSN members are large and small and every size in between. Members are community-based and truly reflect the diversity of the children, youth and families that are served by the agencies. As a network, CFSN has adopted internal rules to ensure that all providers, especially small community-based agencies which traditionally do not have a seat at the table, are represented at every level of the decision-making process.

CFSN members offer a broad range of services and supports for children, youth and their families in Alameda County. Members provide adoption programs, kinship services, foster family recruitment and support, mentoring, housing, respite care, family preservation, residentially-based care, mental health counseling, youth empowerment and educational programs, to name just a few. The network has worked extensively with the Alameda County Social Services Agency and has begun to work with the Alameda County Probation Department and Alameda County Behavioral Services toward the goal of improving the delivery of services to the most vulnerable populations in Alameda County.

For the PEI funding, CFSN recommends the deployment of a *place-based strategy* in order to maximize the impact of limited resources. CFSN is not recommending specific mental health programs or service delivery options but rather a framework for the implementation of services, programs and approaches that are ultimately funded by PEI dollars.

SECTION II - DATA SOURCES: The data sources that support CFSN's recommendation of a place-based strategy include: (1) documentation from the California Department of Mental Health (DMH); (2) Alameda County's initial MHSA planning process which identified the most underserved populations in the county; (3) experience of community-based providers; (4) research regarding the efficacy of place-based strategies; and (5) census tract maps that demonstrate which parts of Alameda County have the highest concentrations of underserved populations.

First, in its proposed guidelines for PEI funding[1], DMH states that, in the interest of *making a difference* "counties are not required to implement PEI projects or programs countywide or address all PEI priority populations." In other words, counties can choose to focus its PEI resources on a discrete set of services and/or a finite geographical area in order to maximize impact. Furthermore, a place-based strategy would, in fact, best encompass the six key concepts set forth by the Mental Health Services Oversight and Accountability Committee (OAC) to bring about transformational change within individuals, families and communities. In particular, a place-based strategy would be the ideal framework for: Community Collaboration, Cultural Competence, Wellness Focus, Client Driven Interventions in Underserved Populations, Integrated Service Experience and Outcomes Based Program Design.[2]

Second, prevalence and service utilization identified by the Alameda County MHSA planning process clearly indicated that two communities – Latino and Asian and Pacific Islander (API) – were significantly underserved in terms of mental health services. In fact, for children and youth, "Caucasians and African Americans are served at nearly four times the rate of API's

[1] *Proposed Guidelines - Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan*, the California Department of Mental Health Mental Health Services Act, September 2007; p. 17.
[2] Ibid.; p. 4.

and three times the rate of Latinos."[3] Moreover, similar disparities exist among Transition Age Youth (ages 16-24), especially for API youth who "are over six times less likely to be served than African Americans and two times less likely than Caucasians."[4] Research has indicated that these disparities are due, in part, to insufficient funding for community based programs, the lack of culturally competent services, the limited availability of multi-lingual staff and a number of deeply-rooted cultural barriers that often prevent Latino and API children and adults from seeking out mental health services – all issues that could be positively addressed by a place-based strategy.[5]

Third, mental health service providers in Alameda County (many of them members of CFSN) have found, through their outreach and service efforts that Latinos, API's and Native Americans – a community which faces similar barriers to care – are more likely to visit a community center first, rather than a mental health clinic, even when in need of counseling services. Staff at community-based centers in the Latino, API and Native American communities have become increasingly adept at establishing and building trusting relationships that can often lead to the provision of non-stigmatized counseling services. Such interactions would be best facilitated in a neighborhood-based service delivery system.

Fourth, the research regarding place-based strategies has begun to show that tremendous gains can and have been made in terms of positive community change.[6] The best example of a place-based strategy is the *Harlem Children's Zone*, quite arguably the most comprehensive and successful place-based efforts in the nation. This effort started in a one block radius and grew to the point that it now encompasses a large section of Harlem and provides the full range of services and supports for an entire community.[7] Nevertheless, a place-based strategy is not a panacea for ending poverty, reducing crime or improving community mental health. However, deploying targeted resources in several underserved communities will undoubtedly have a far greater impact than spreading those same scarce resources over an entire county.

And, fifth, a review of census tract maps (see attached) that graphically illustrate the percentage of Latino, API and Native American populations throughout Alameda County can serve as a guide to identify the neighborhoods with the highest concentrations of underserved populations. For Latinos, those areas would include the San Antonio and Fruitvale neighborhoods of Oakland as well as South Hayward and parts of Union City. For API's, they would include Oakland Chinatown, San Antonio and Fremont. And although the Native American population is quite dispersed throughout the county, community-based service providers located have identified that the San Antonio and Fruitvale neighborhoods seem to be a community gathering place.

SECTION III - RECOMMENDATIONS: Based on the aforementioned data and research, CFSN is proposing that the Alameda County PEI funding be focused in target neighborhoods with a high concentration of underserved populations.

To be clear, CFSN is not recommending specific service delivery strategies. Rather, members of CFSN propose that the intervention strategies selected for PEI funding be implemented in several target neighborhoods that would be determined after a more detailed study. The attached census maps are merely a start. To identify target neighborhoods, a deeper analysis would be needed to correlate other socio-economic factors, service utilization, asset mapping and existing neighborhood-based initiatives and collaborations.

As a focused effort, PEI funding could be used to jump-start a comprehensive neighborhood-based strategy that will support all children, youth and their families. Since Latinos, API's and Native Americans tend to connect in different ways to mental health services, it would make sense to view this place-based strategy as an opportunity for collaboration with various public and private agencies, such as social services, schools, health care, child care, etc. In addition, this framework would be a tremendous opportunity for BHCS to continue its efforts to partner with public agencies and community-based providers to leverage resources and maximize impact.

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[3] *Executive Summary of the Community Services and Supports Plan,* Alameda County Behavioral Health Care Services, Mental Health Services Act ,November 11, 2005; p. vii.
[4] Ibid, p. vii.
[5] Ibid, p. ix.
[6] *Using Place-Based Random Assignment and Comparative Interrupted Time-Series Analysis to Evaluate the Jobs-Plus Employment Program for Public Housing Residents*, Howard S. Bloom and James A. Riccio, November 2002.
[7] http://hcz.org/documents/2007report.pdf, http://www.hcz.org/media/business_plan.pdf

As a starting point, this place-based effort should be focused in a small neighborhood (approx. 4-8 block radius) with the following guiding principles:

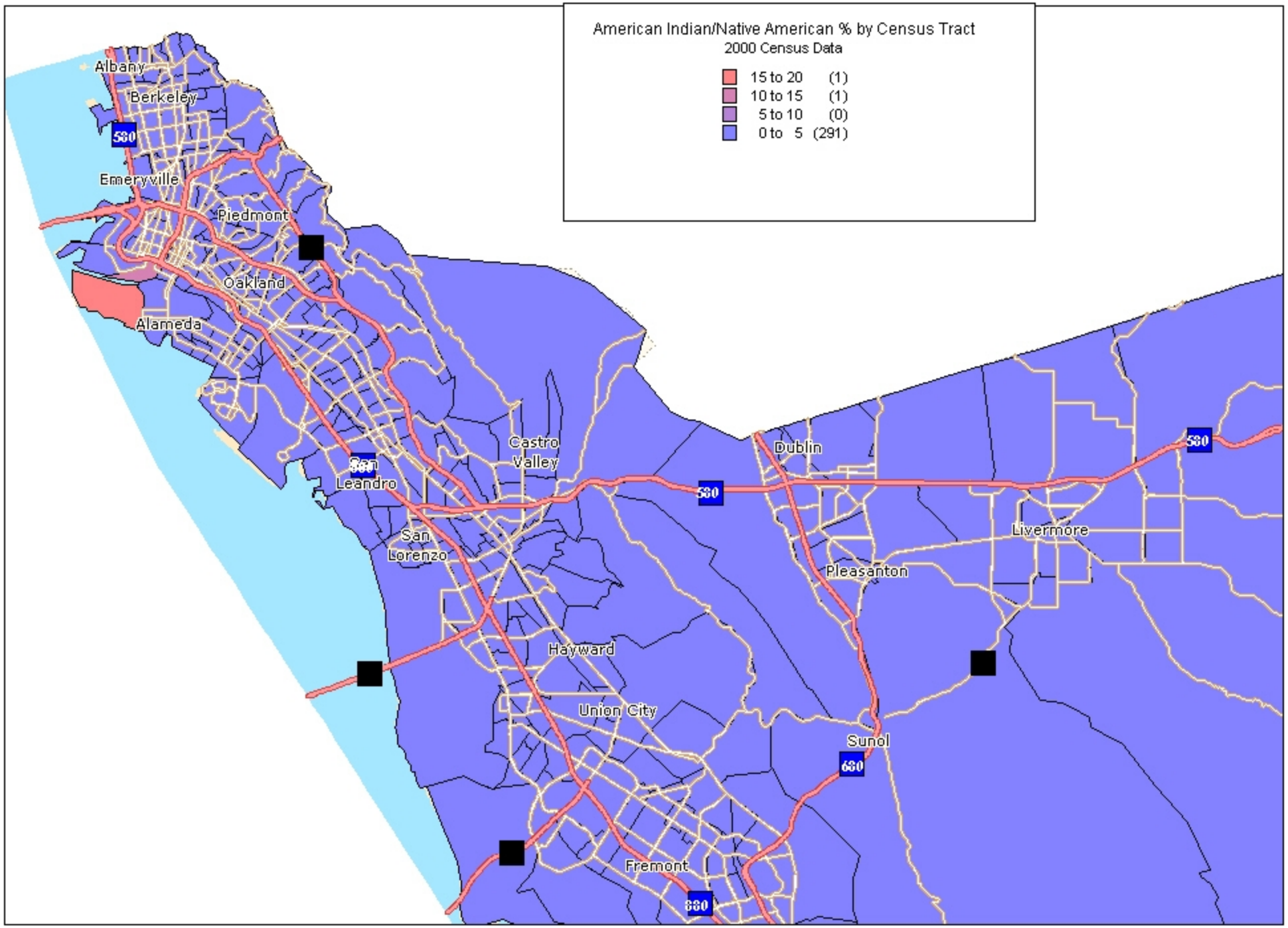
- Emphasizing youth, family and community empowerment
- Connecting with other collaborations, groups and initiatives
- Working with all children, youth and families
- Partnering with local, community-based organizations
- Expanding informal access to mental health services
- Providing a broad-range of services and supports, including job training, job creation, after school programs, drug suppression, economic development, housing, family preservation, kin guardianship, in-home visits, respite care, etc.

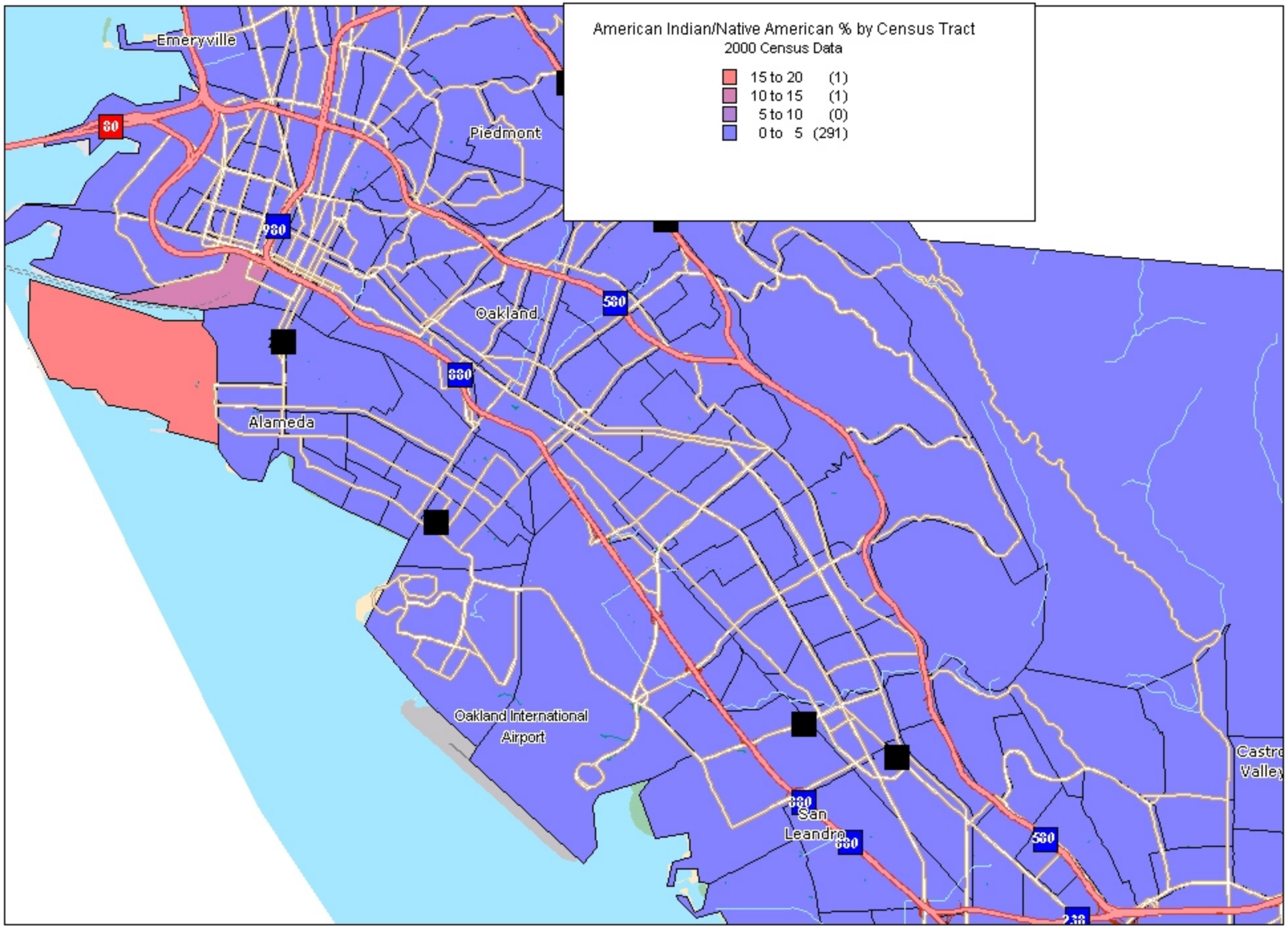
Such a vision would dovetail with the vision of the Harlem Children's Zone "whose work is not just on education, social service and recreation, but on rebuilding the very fabric of community life."[8] Now in its fourth decade of work, the leaders of the Harlem Children's Zone have identified the two main tenets for transformational change and positive youth development: "a critical mass of engaged, effective families and early and progressive intervention in children's development."[9]

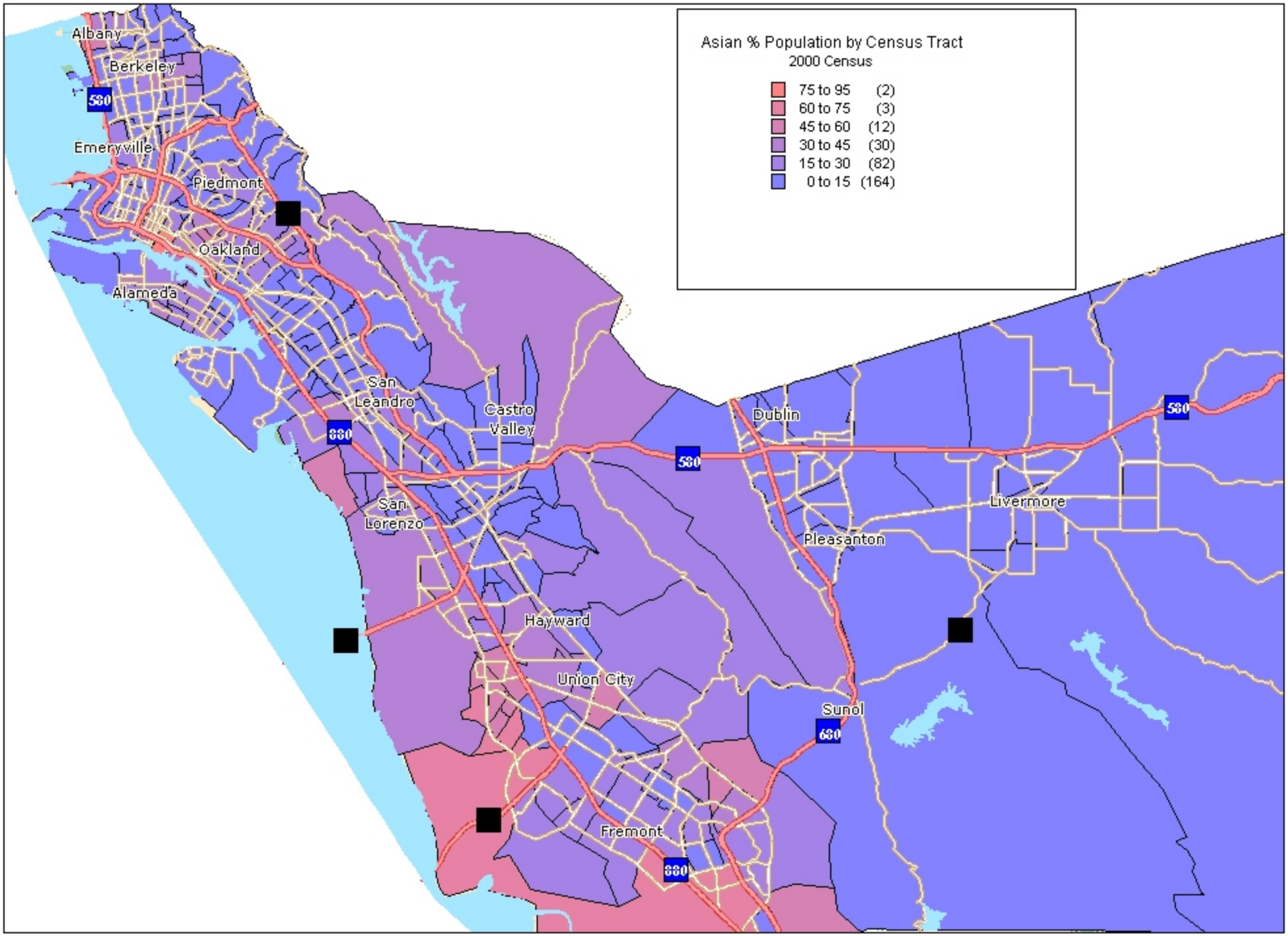
In other words, supporting families and intervening early and often in the lives of children a community will have the most profound impact on our community. With a place-based strategy funded by PEI dollars, such a vision is within our reach.

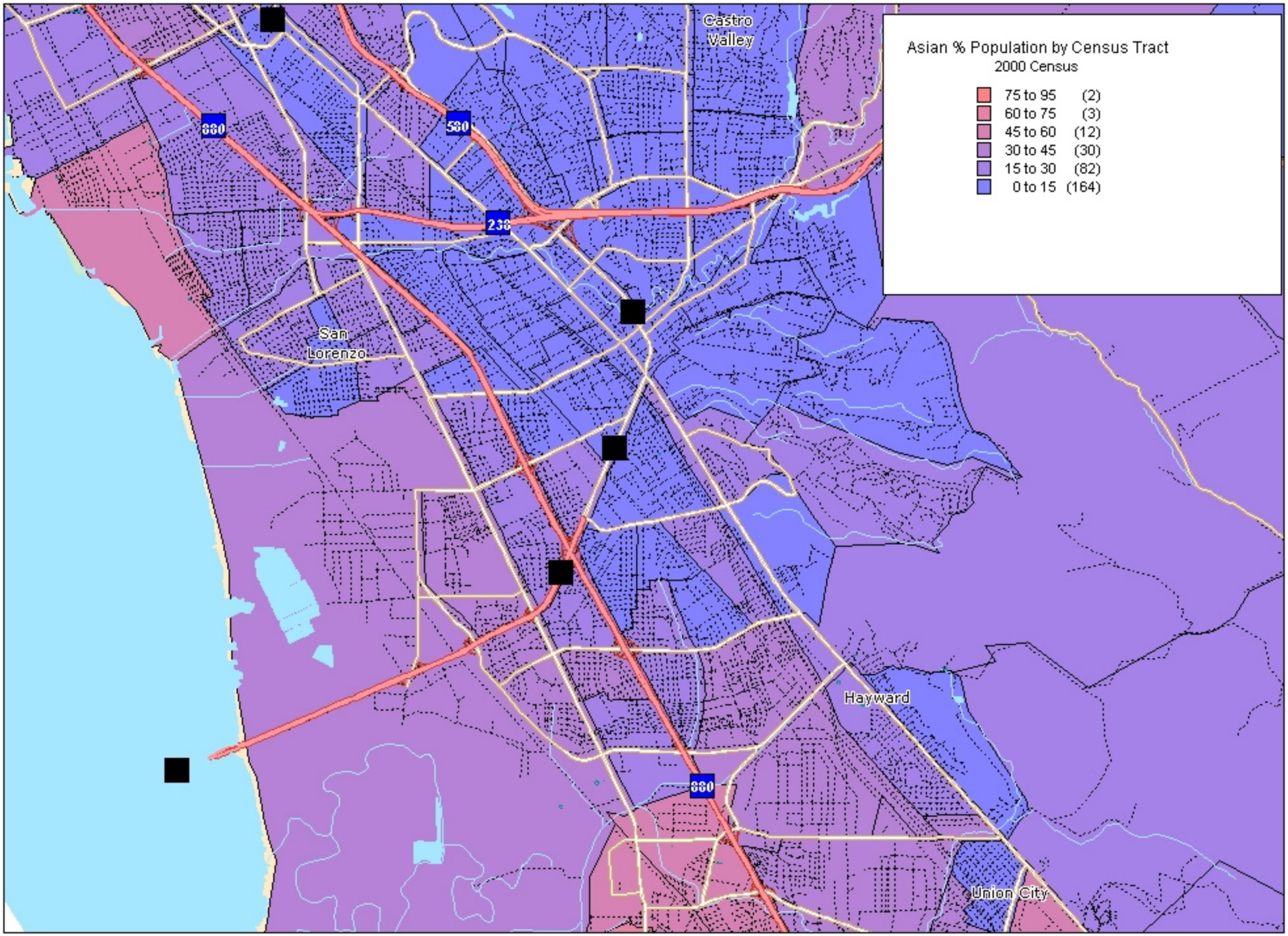
[8] Harlem Children's Zone Business Plan, Fall 2003; p. ii.
[9] Ibid; p. ii.

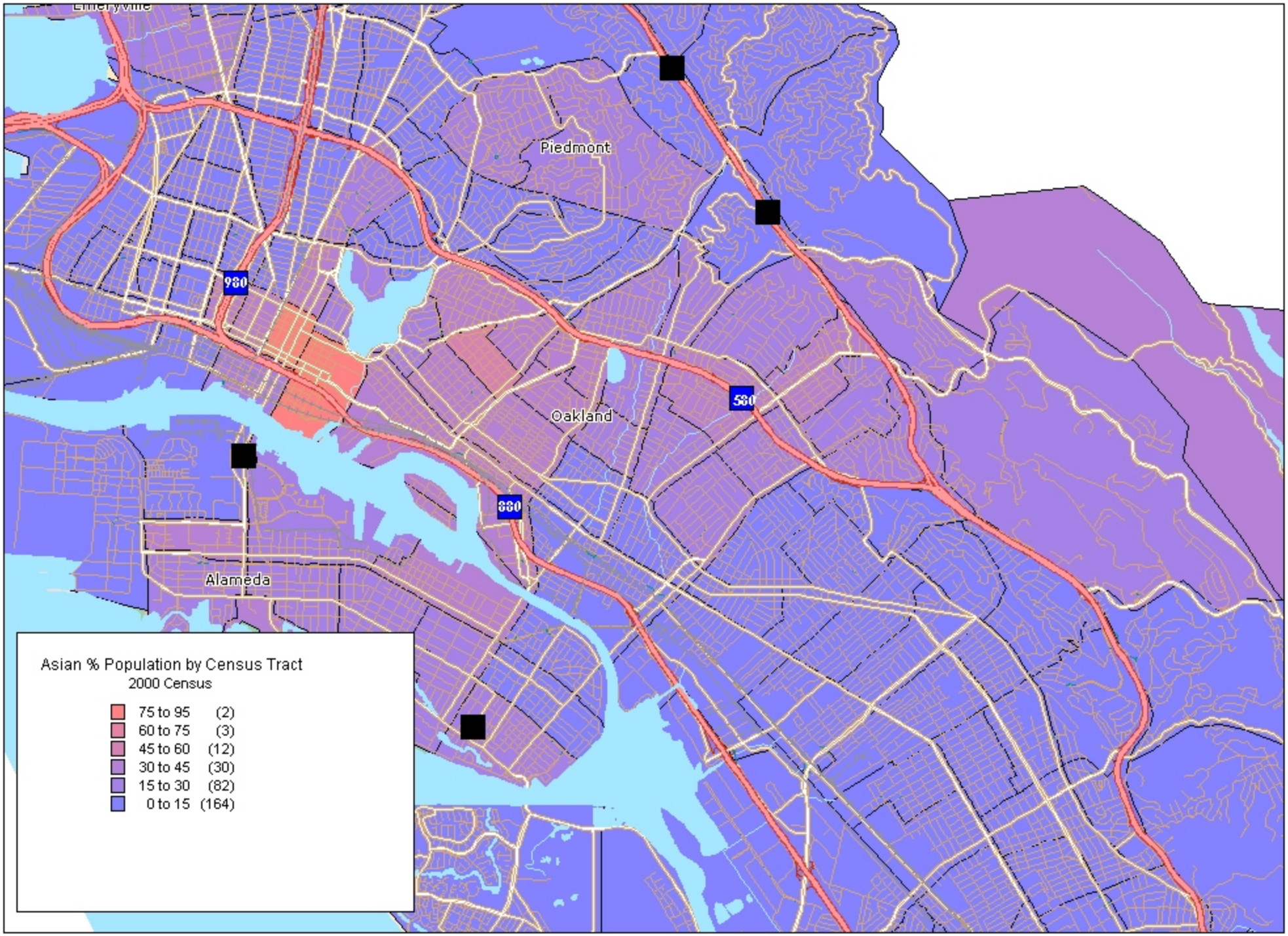
| First | Last | Organization | Title |
|---|---|---|---|
| **Members** | | | |
| Jay | Berlin | Alternative Family Services | Executive Director |
| Ken | Berrick | Seneca Center | President and CEO |
| Washington | Burns, M.D. | Prescott-Joseph Center | Executive Director |
| Sam | Cobbs | First Place Fund for Youth | Executive Director |
| Lou | Fox | Family Support Services | Executive Director |
| Bob | Goetsch | Be A Mentor, Inc. | President |
| Mary Jane | Gross | STARS Behavioral Health Group | President |
| Zula | Hamilton | Cassio | Director |
| Madge | Haynes | Casey Family Programs | Field Office Director |
| Jason | Henderson | The REFUGE | Executive Director |
| Jill | Jacobs | Family Builders by Adoption | Executive Director |
| Stacey | Katz | Westcoast Children's Clinic | Executive Director |
| Beatrice | Lee | Asian Pacific Psychological Services | Executive Director |
| Josh | Leonard | Bay Area Youth Centers | Executive Director |
| Shahnaz | Mazandarani | A Better Way, Inc. | Executive Director |
| Ty | McClain | A New Way of Life | Executive Director |
| Barbara | McCullough, Ph.D | Brighter Beginnings | Executive Director |
| Shannon | McGiffin | Kairos Unlimited, Inc. | Executive Director |
| Terry | Pace | T & T | Executive Director |
| Dorothy | Simpson | Simpson Outreach | Asst. Director |
| John | Steinfirst | Fred Finch Youth Center | Executive Director |
| Vernice | Steward | Stew's Love 'N' Care | Executive Director |
| Chris | Stoner-Mertz | Lincoln Child Center | President and CEO |
| Tony | Thurmond | Beyond Emancipation | Executive Director |
| Mary | Trimble Norris | American Indian Child Resource Center | Executive Director |
| **Affiliates** | | | |
| Carol | Brown | City of Berkeley CHDP | Deputy Director |
| Jodie | Langs | Alameda County Foster Youth Alliance | Executive Director |
| Pastor Raymond | Lankford | Healthy Oakland | Executive Director |
| Elizabeth | Tarango | FYS-ACOE | Coordinator |


American Indian/Native American % by Census Tract
2000 Census Data
15 to 20 (1)
10 to 15 (1)
5 to 10 (0)
0 to 5 (291)
Albany
Berkeley
Emeryville
Piedmont
Oakland
Alameda
San Leandro
Castro Valley
San Lorenzo
Hayward
Union City
Fremont
Dublin
Pleasanton
Livermore
Sunol
580
680
880


American Indian/Native American % by Census Tract
2000 Census Data
15 to 20 (1)
10 to 15 (1)
5 to 10 (0)
0 to 5 (291)
Emeryville
Piedmont
Oakland
Alameda
Oakland International Airport
San Leandro
Castro Valley
80
980
880
580


Asian % Population by Census Tract
2000 Census
75 to 95 (2)
60 to 75 (3)
45 to 60 (12)
30 to 45 (30)
15 to 30 (82)
0 to 15 (164)
Albany
Berkeley
Emeryville
Piedmont
Oakland
Alameda
San Leandro
Castro Valley
San Lorenzo
Hayward
Union City
Fremont
Dublin
Pleasanton
Livermore
Sunol
580
880
680


Asian % Population by Census Tract
2000 Census
75 to 95 (2)
60 to 75 (3)
45 to 60 (12)
30 to 45 (30)
15 to 30 (82)
0 to 15 (164)
Castro Valley
880
580
238
San Lorenzo
Hayward
880
Union City


Piedmont
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Oakland
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Alameda
Asian % Population by Census Tract
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75 to 95 (2)
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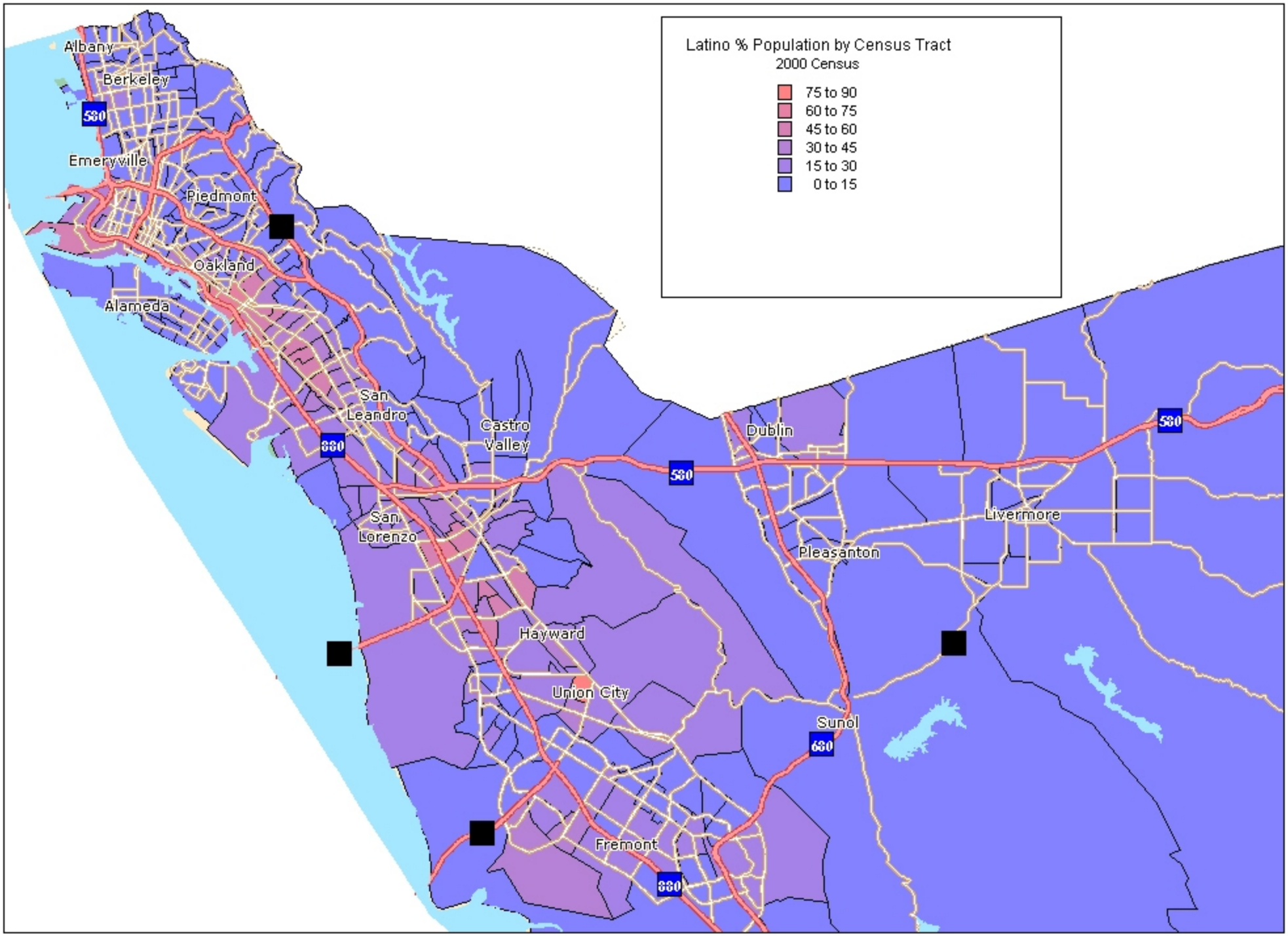
Latino % Population by Census Tract
2000 Census
75 to 90
60 to 75
45 to 60
30 to 45
15 to 30
0 to 15
Albany
Berkeley
Emeryville
Piedmont
Oakland
Alameda
San Leandro
Castro Valley
Dublin
Livermore
Pleasanton
San Lorenzo
Hayward
Union City
Sunol
Fremont
580
880
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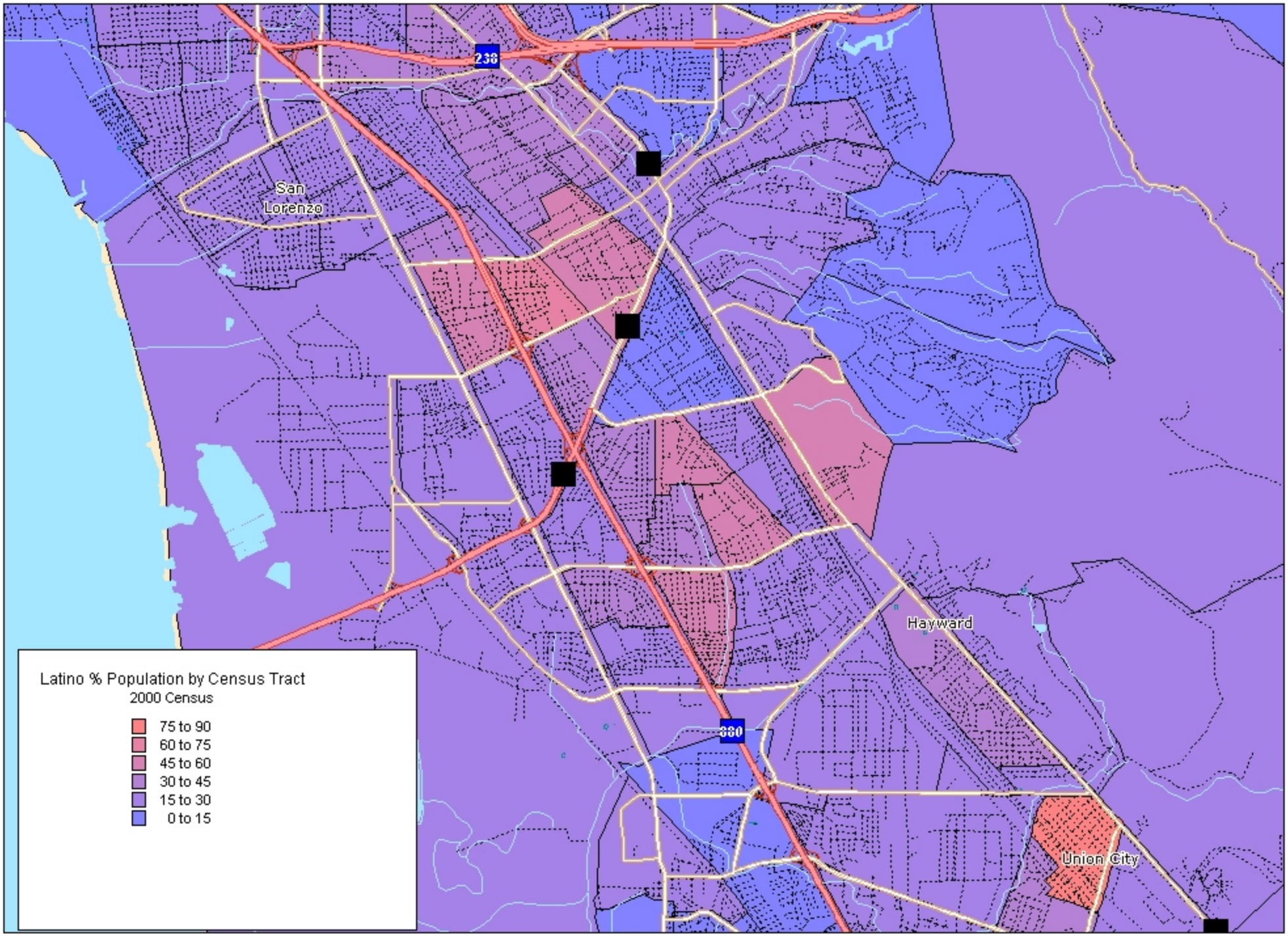
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San Lorenzo
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Latino % Population by Census Tract
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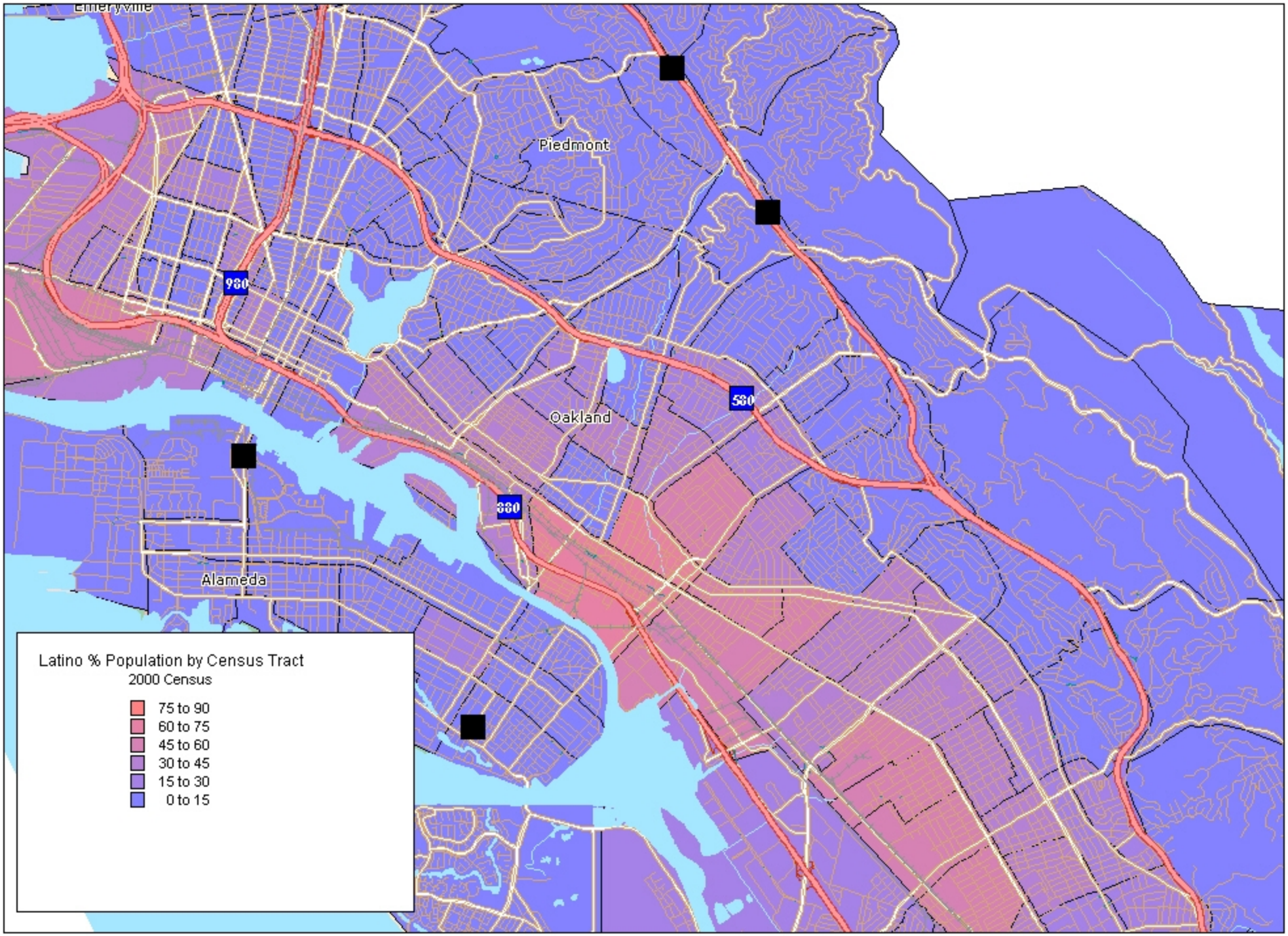
75 to 90
60 to 75
45 to 60
30 to 45
15 to 30
0 to 15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60 to 75
45 to 60
30 to 45
15 to 30
0 to 15

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:
1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

| | |
|---|---|
| Organization* (if applicable): | Fred Finch Youth Center |
| Contact Person: | John F. Steinfirst, LCSW, President & CEO |
| Address: | 3800 Coolidge Avenue, Oakland, CA 94602 |
| Phone No./ Email address: | (510) 482-2244 (x214) \| johnsteinfirst@fredfinch.org |

***Please attach a list of all groups and organizations that contributed to this report.***

***What age group does your organization serve or represent?***

☒ Children & Youth (0-18) ☒ Transition Age Youth (14-25) ☐ Older Adults (60+)

☐ Adults (18-59)

***Under each category, choose the item your report PRIMARILY addresses:***

Key Community Mental Health Needs

☐ Disparities in Access to Mental Health Services
☒ Psycho-Social Impact of Trauma
☒ At-Risk Children, Youth and Young Adult Populations
☐ Stigma and Discrimination
☐ Suicide Risk

Priority Populations

☒ Underserved Cultural Populations
☐ Individuals Experiencing Onset of Serious Psychiatric Illness
☒ Children/Youth in Stressed Families
☒ Trauma-Exposed
☒ Children/Youth at Risk for School Failure
☒ Children and Youth at Risk of Juvenile Justice Involvement

**For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

**ALAMEDA COUNTY CHILDREN'S ADVISORY COMMITTEE PREVENTION AND EARLY INTERVENTION RECOMMENDATIONS EXECUTIVE SUMMARY**

SECTION I - ORGANIZATIONAL BACKGROUND:

The Children's Advisory Committee (CAC) is a sub-committee of the Mental Health Board, and as such convenes on a monthly basis. The CAC consists of providers of Mental Health Services delivered by both county operated sites and Community Based Organizations. As providers of mental health services the CAC membership understands the importance of Prevention and Early Intervention Services. These services provide a mechanism to help prevent the escalation of mental health problems, thereby, allowing children and youth to mature in a developmentally appropriate manner.

Based on CAC's belief in the importance of prevention and early Intervention, the CAC convened a work group of its membership to develop and submit a strategy for use of MHSA, Prevention and Early Intervention (PEI) funding. The CAC process for developing its strategy involved convening and facilitating two large brainstorming sessions with the CAC membership. In total, over 50 people participated in these brainstorming sessions. As an outcome of the large group discussions, CAC identified a small workgroup to take the feedback from the brainstorming sessions and frame the CAC priority recommendations and strategies for PEI. CAC has worked with its member organizations and other county stakeholders, namely, Alameda County School Health Services Coalition, the HUSKEY Committee and Alameda County Early Childhood Mental Health Planning Committee to envision what a comprehensive mental health care continuum for children and youth in Alameda County would comprise. (Please see Attachment 1: CAC Mailing List.)

Based on input from CAC members and the outcome from our collaborative discussions, the CAC recommends the implementation of three strategies to address the unmet prevention and early intervention needs of At Risk Children and Youth among the following priority populations:

- Children/Youth in Stressed Families
- Trauma-Exposed Youth, Children/Youth at Risk for School Failure
- Children and Youth at Risk of Juvenile Justice

Specifically, CAC proposes the implementation of evidence based strategies in the schools and in primary care settings that will improve screening, assessment, and linkages to services for elementary school age children who experience trauma.

SECTION II - DATA SOURCES:

CAC supporting data for the PEI recommendations was derived from primarily from three sources: 1) Published research on childhood trauma and evidence based practices for prevention and early intervention to reduce mental illness and related poor health outcomes; 2) CAC brainstorming sessions with member child advocates, youth advocates, and behavioral health providers; and 3) Strategic planning discussion with child, youth, and family centered organizations that represent unique strands of the child and youth population in Alameda County. Specifically, the data and information represent:

- **Published research on childhood trauma:** Key research data is derived from three sources: 1) the National Child Traumatic Stress Network (NCTSN), a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education;[1] 2) studies on trauma among youth in the juvenile justice system; and 3) mental health intervention strategies for schoolchildren exposed to violence. Traumatized youth can be from any background, but those who experience significant early life trauma often come from environments in which they are subject to more stress and have fewer resources to help them develop than children who do not suffer early life trauma. Traumatic experiences can include not only physical or sexual abuse or assault but also serious accidents, illnesses, disasters, and the loss of important relationships or caregivers. When trauma occurs early in childhood, critical aspects of brain and personality development may be disrupted.[2, 3] Several studies have found that the majority of children exposed to violence, defined as personally witnessing or directly experiencing a violent event, display symptoms of posttraumatic stress disorder (PTSD).[4]

[1]NCTSN comprises 70 member centers-45 current grantees and 25 previous grantees-and is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative. 2 Ford, J.D. (2002). Traumatic victimization in childhood and persistent problems with oppositional-defiance. *J Trauma, Maltreatment, and Aggression, 11,* 25-58. 3 Ford, J. D. (2005). Treatment implications of altered neurobiology, affect regulation and information processing following child maltreatment. *Psychiatr Ann, 35,* 410-419. 4 Cuffe SP, Addy CL, Garrison CZ, et al. Prevalence of PTSD in a community sample of older adolescents. *J Am Acad Child Adolesc Psychiatry.* 1998;37:147-154. Horowitz K, Weine S, Jekel J. PTSD symptoms in urban adolescent girls: compounded community trauma. *J Am Acad Child Adolesc Psychiatry.* 1995;34:1353-1361.

Exposure to violence is associated with depression[5] and behavioral problems. [6,7,8] Exposure to violence also may interfere with the important developmental milestones of childhood and adolescence. Interventions that address the needs of children who are experiencing a range of symptoms after witnessing or experiencing violence are needed.

 **CAC brainstorming sessions:** Over 50 individuals including CAC members, community and school-based mental health providers, and key policymakers in Alameda County participated in planning discussion between March and October of 2007. These meetings provided a forum for discussing the mental health needs of children and families within the context of meeting the objectives of the MHSA, PEI funding. Participants discussed the prioritization of defined needs and myriad strategies and solutions. From this group process a seven member workgroup was formed and charged with taking the large group input and formulating a framework for the CAC PEI strategy.

 **Strategic planning discussions:** The CAC workgroup engaged in strategic discussions with other key stakeholder groups, e.g., Alameda County School Health Services Coalition, HUSKEY, and Alameda County Early Childhood Mental Health Planning Committee to flesh-out a children and youth strategy. This CAC summary reflects the best practices review, feedback from planning discussions, and deliberation by the workgroup.

SECTION III - RECOMMENDATIONS:

Children exposed to traumatic events exhibit a wide range of symptoms, presenting with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior.[9] Early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening. Without intervention, child and adolescent disorders frequently continue into adulthood.

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations, and this exposure overwhelms their ability to cope with what they have experienced.[10] Large numbers of US children experience violence, and an even greater number may experience symptoms of distress after personally witnessing violence directed at others. Traumatic events can include physical abuse, sexual abuse, domestic violence, community violence, and/or disasters.[11] Although estimates vary, it is believed that the prevalence of trauma among children and youth in the general population is substantial. In one nationally representative survey of 9–16 year olds, 25% reported experiencing at least one traumatic event, 6% in the past 3 months.[12] The National Center on Child Abuse and Neglect reports that more than 2% of all children are victims of maltreatment, 13% are victims of neglect, and 11% are victims of physical, sexual, or emotional abuse.[13]

While some children bounce back after adversity, traumatic experiences can result in a significant disruption of child or adolescent development and have profound long-term consequences. Repeated exposure to traumatic events can affect the child's brain and nervous system and increase the risk of low academic performance, engagement in high-risk behaviors, and difficulties in peer and family relationships. Traumatic stress can cause increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems. **CAC PEI Strategy**

CAC recommends universal screening, assessment, and referral for trauma in elementary school age children at schools and in primary care settings. Evidenced based practices would be used to implement universal screening, comprehensive assessment, and linkage of children to appropriate services who are at risk of developing PTSD after a traumatic accident, injury or exposure.[14] Based on the information gathered in the trauma screening, it is expected that there will be elementary age school children that will need trauma specific early intervention services. These services should be short term (up to 12 months) and designed to help prevent the escalation of mental health issues that result from trauma exposure. **Implementation of Trauma Focused Evidenced Based Practices (EBP)** In addition to universal screening tools, the following EBPs are recommended for use in this care system: [14] These tools are identified by the California State Department of Mental Health in the MHSA Resource Materials Document.

- **Universal screening tools** comprised of one or more of the following: *The Child Trauma Screening Questionnaire, the Children's Impact of Events Scale*, the Anxiety Disorder Interview Schedule for DSM IV (Child Version), or the Clinician-administered *PTSD Scale for Children and Adolescents*
- **Cognitive – Behavioral Intervention for Trauma in School (CBITS):** A skills-based, group intervention aimed at relieving symptoms of PTSD, depression, and anxiety among children exposed to trauma, and teaching them resiliency and coping skills.
- **Trauma Focused Cognitive Behavioral Therapy (TFCBT):** A SAMHSA model program designed to help

5 Kliewer W, Lepore SJ, Oskin D, Johnson PD. The role of social and cognitive processes in childrens adjustment to community violence. *J Consult Clin Psychol.* 1998;66:199-209. 6 Fitzpatrick KM, Boldizar JP. The prevalence and consequences of exposure to violence among African-American youth. *J Am Acad Child Adolesc Psychiatry.* 1993;32:424-430. 7 Martinez P, Richters JE. The NIMH Community Violence Project, II: children's distress symptoms associated with violence exposure. *Psychiatry.* 1993;56:22-35. 8 Farrell AD, Bruce SE. Impact of exposure to community violence on violent behavior and emotional distress among urban adolescents. *J Clin Child Psychol.* 1997;26:2-14. 9 Ibid. 10 Julian D. Ford, PhD, Department of Psychiatry, University of Connecticut School of Medicine 11 John F. Chapman, PsyD, State of Connecticut Judicial Branch, Court Support Services Division 12 Josephine Hawke, PhD, Department of Psychiatry, University of Connecticut School of Medicine 13 John F. Chapman, PsyD, State of Connecticut Judicial Branch, Court Support Services Division

children, youth, and their parents overcome the negative effects of traumatic life events.

Service implementation should be based on school site selection following an analysis of data available form Public Health, BHCS, SSA, local law jurisdictions, Emergency Medical Services, and all other applicable programs where exposure to trauma can be identified. Linkages should be extended to community programs (Family Law Center, Another Road to Safety-ARS, etc.) that work with trauma exposed youth so that referrals can be expedited when exposed youth live in an area with a PEI Trauma Focused Program. A thorough review of existing trauma services should be conducted and as indicated, additional training should be provided to programs (school and community based) to build their capacity to recognize the early signs of trauma as an adjunct to standardized screening tools, and to enhance their utilization of the recommended EBP. Primary care settings will be identified and/or connections to primary care settings to participate in this strategy will be developed.

**Anticipated Outcomes**

| EBP STRATEGY | INTENDED OUTCOMES |
|---|---|
| **Cognitive Behavioral Intervention for Trauma in School (CBITS)** | □ Improvements in behaviors related to protective factors<br>□ Reductions in behaviors related to risk factors<br>□ Lower post-traumatic stress and depressive symptoms<br>□ Lower psychosocial dysfunction |
| **Trauma Focused Cognitive Behavioral Therapy (TFCBT)** | □ Reduction in behavior problems<br>□ Reduction in PTSD symptoms, i.e. depression, self-blame, defiant and oppositional behaviors, anxiety<br>□ Improved social competence (maintained for one year)<br>□ Improved adaptive skills for dealing with stress; decreased anxiety for thinking or talking about the event; enhanced accurate/helpful cognitions and personal safety skills and parental support |

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) Huskey Tracking Committee
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**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

X Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)
[Special Emphasis on Children/Youth 11-19]

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

X Disparities in Access to Mental Health Services [2ndary]
X Psycho-Social Impact of Trauma [2ndary]
X At-Risk Children, Youth and Young Adult Populations [Primary]
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

❒ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
X Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement [Primary]

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

SECTION I – ORGANIZATIONAL BACKGROUND:

The Comprehensive Study of the Alameda County Juvenile Justice System, prepared by Huskey & Associates, analyzed gaps in community-based services, assessed impediments in case processing, and developed strategies to reduce the number of youth detained in Juvenile Hall. The "Huskey" report, released in December 2004, drew its findings from comprehensive data collection, program analysis, research into best practices and evidence-based models in use in California and throughout the nation, and consideration of viable local options.

The Huskey Study Tracking Committee facilitates, monitors, and advises on implementation of the Huskey report's recommendations. (See a list of agencies in Appendix A). The report's recommendations are designed to enhance and reexamine existing policies, practices and programs to improve their effectiveness. The Committee was given the task to determine which recommendations should be given highest priority, which were most feasible for implementation, and which were most critically needed within budgetary constraints. Recommendations in this document are linked to specific text contained in the Huskey Report's Final Report Vol. 1: Executive Summary and Recommendations (attached), and are conceptually linked and integrated with ongoing implementation of service and system improvements, as noted in the Report.

SECTION II – DATA SOURCES:

Recommendations are based on 1) Alameda County and national studies; 2) the Huskey Report's in-depth analyses of juvenile justice, its recommendations for future action and proceedings of the Huskey Tracking Committee; and 3) expertise of a coalition of service providers in mental and behavioral health, juvenile justice, probation, delinquency prevention, substance abuse treatment, schools, school health, and social welfare.

1) Recent data from over 400 youth in Alameda County detention show more than 50% report high levels of general life problems; internal behavior problems; external behavior problems and substance use/abuse problems (Shane, 2004). *Significantly, in a comparison of younger and older adolescents ( $\leq$ 15 vs. > 15), behavior patterns and symptoms tend to become more prevalent, more frequent, and have greater negative consequences as adolescents become older.* Currently, we fail to identify early enough. Too much time elapses between the onset of problems and the time when age and developmentally appropriate service response is provided. For those with substance abuse problems the average age for entering substance abuse treatment is 16; however, they were, on average, 11 years old when they began to use drugs (Shane, 2002, 2004). When 5 years elapses without intervention during adolescence, dysfunction grows and youth fail to achieve critical psycho-social developmental landmarks. Children are not well served when problems are addressed only after they have escalated.

Although the average age of serious male offenders at their first contact with the juvenile justice system is reported as 14.5 years (OJJDP), *research shows actual delinquency careers start much earlier,* typically beginning to have minor problems at age 7, progressing to moderately serious behavior problems at age 9.5, and committing serious delinquency offenses at age 11.9. "On average, more than 7 years elapses between the

earliest minor problem behaviors and the first court appearance for an offense" (Loeber & Farrington, 1998). Early intervention delivered through comprehensive community interventions is most effective. Efficacy requires a coordinated response from juvenile justice, mental health systems, schools, behavioral health care, and child welfare agencies. Consensus in mental health and criminal justice is that "if people with mental illness received the treatment they needed, the vast majority of them would not end up in our jails and prisons." (Resource Document, American Psychiatric Assoc. May, 2004.)

2) Early intervention with children at risk for delinquent behavior is crucial. The Huskey report recommends adoption of formal mechanisms to screen for mental health problems. It found that 23% of pre-adjudicated youth and 31% of post-adjudicated minors could be considered for alternatives to detention. It specifically recommends mental health wraparound services for youth, provided in the community, consistent with system-of-care strategies. It recommends use of standard risk and needs assessment instruments, including mental health screening tools and a pre and post test for every child involved in an alternative to detention. *Currently, most minors charged with misdemeanors or minor felonies are referred to juvenile intake where the majority (77%) of cases are closed and receive no further services. Analysis finds that 51% of the cases closed at intake are later rearrested, often for more serious offenses.*

3) Committee members, experts from a coalition of Alameda County organizations, have met monthly for 3 years to address recommendations, to devise implementation strategies that fit local circumstance, and to prioritize critical service needs of high-risk youth and families. [See attached 8 Section Response Document.] Needs assessed for youth and families in over 1,800 cases (7/2004-6/2007) show family counseling, parent skill training/support, and individual counseling for youth among the top 5 most frequently cited (Youth Service Centers, 2007). Risk factors most frequently cited for these youth included: overwhelmed parents/guardians; depression, anxiety, emotional difficulties; high conflict relational problems; drug/alcohol problems; and self-destructive behavior.

SECTION III – RECOMMENDATIONS:

The population of youth described in Welfare and Institutions Code Section 602 has significant mental health and behavioral needs, but needs vary based on individual experience, family systems, and effects of trauma, bio-psycho-social differences, chronological age, and developmental maturation. It is critical that strategies reflect developmentally appropriate, culturally competent, and evidence-based approaches.

- **Expand mental health screening, assessment, linkages and support services** in alignment with those implemented at JJC (i.e. YLS, MAYSI, HEADSSS) for all youth identified as 602, as described in the Welfare and Institutions Code.
- **Establish common definitions and shared/common criteria for risk, referral, and intervention** using a universal screening tool, and common problem identifiers to facilitate earlier problem identification and intervention.
- **Increase awareness about mental health problems, and help seeking behavior** among family members and caregivers.
- **Implement early intervention in a manner that effectively interrupts the development of maladaptive behaviors** among youth and ends the trajectory of

escalating criminal activity. Focus on lower-level 602 youth, 1st time offenders, who are experiencing problems with adherence to probation conditions. Specifically, introduce mental health interventions that are evidence-based for juvenile justice involved youth, i.e. CBT, MST, FFT.

- **Integrate and link evidence-based intervention strategies throughout the current network of providers** that serve high-risk youth in the community. Link families to vital resources to address problems with substance abuse and family violence
- **Use early intervention to identify mental health and psycho-social needs, strengthen social support, build emotional development, and promote well-being.**

Main Points:

- 1) Prevention and early intervention service capacity will be integrated into practices and protocols of existing programs and services;
- 2) Linkages to existing programs will include delinquency network providers, EPSDT providers, multi-disciplinary teams, and collaborations, e.g. Our Kids, School Based Health Centers;
- 3) Integration of best practices will include -- training and professional development, advocacy for families, mechanisms for delivery of screening, assessment and link to services, strengthening identification and intervention capability;
- 4) High Risk Youth are defined to include: abuse/neglected children; truant; AWOL and runaway youth; transitional youth out of foster care and out of juvenile justice; gang identified youth; homeless and exploited youth; youth exposed to violence; youth with multiple contacts with law enforcement;
- 5) These are cost effective and less stigmatizing strategies to deliver mental health services, leverage existing services and funding streams to serve a critical population of at risk youth and families, many of whom are low-income, indigent, and uninsured.

Leveraging Revenue & Cost Benefit:

- Funds would be allocated to maximize and further leverage existing resources such as EPSDT; Measure Y, JPCF; Targeted Case Management for MediCal Populations; and MAA (administrative overhead).
- Cost Savings would result from avoiding fiscal expenditures to address repeat offenders, subsequent incarceration, and community costs of illegal activity. Early intervention for mental health problems produces savings in subsequent treatment of acute episodes, interrupting a potential chain of events that traumatizes or exacerbates existing problems, escalating consequences, e.g. chronic mental health symptoms, related disability/dysfunction in education, employment, and efforts to achieve stable adult relationships (Howell, 2003; Loeber & Farrington, 1998).

| **Recommended Populations** | **Leveraged Funds** |
|---|---|
| Notice To Appear (NTAs) & Probationers (Lower Level) | EPSDT, Measure Y |
| 602 Diversion | City, JPCF, EPSDT |

# ORGANIZATIONS CONTRIBUTING TO THE DOCUMENT AND ITS RECOMMENDATIONS

Alameda County, Board of Supervisors

Alameda County, Probation Dept

Alameda County, County Administrators Office

Alameda County, Health Care Services Agency

Alameda County Office of Education

Oakland Unified School District

League of Women Voters

Berkeley Youth Alternatives

City of Hayward, Youth and Family Services Bureau

City of Fremont, Youth and Family Services

Center for Family Counseling

Alameda Family Services

East Bay Agency for Children

Eden Counseling Services

First Place for Youth

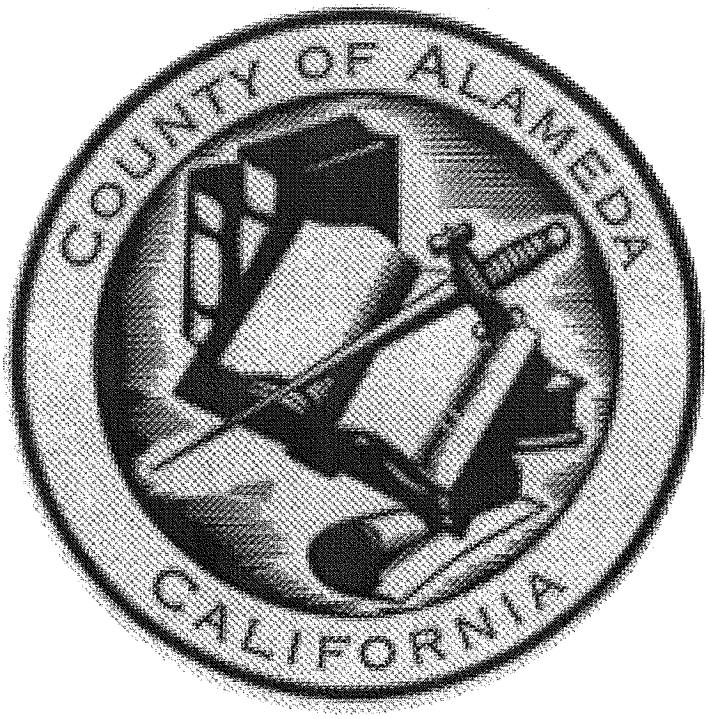
McCollum Youth Court

La Familia

Horizon Services

George P Scotlan Youth & Family Center

# Alameda County, California Comprehensive Study of the Juvenile Justice System




## Final Report

### *Volume 1:*

### *Executive Summary and Recommendations*

**Submitted by:**
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**December 31, 2004**

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## *Volumes 1, 2 & 3*

# Table of Contents
## *Volumes 1, 2 & 3*

*"We want books that describe guns, violence, sex and drugs"*

*"The only role model I've had is my brother and he is a criminal"*

***Two unsolicited statements from minors confined in the Alameda County Juvenile Hall***

# 1.0 Executive Summary and Recommendations

# 1.0 Executive Summary and Recommendations

These unsolicited statements made by two minors detained in Alameda County's Juvenile Hall underscores the urgency to change the attitudes, thinking patterns, and potentially violent behaviors of juvenile offenders involved with Alameda County's Juvenile Justice System. It also reveals the importance of providing positive role models and support services to the families/caregivers of these children to develop their skills.

The findings of this *Comprehensive Study of the Alameda County Juvenile Justice System* will highlight the many strengths of the current juvenile justice system. The study also identified existing gaps and ways in which the system can be strengthened. These are proposed in order to position the juvenile justice system to meet the challenges facing Alameda County's juvenile justice service delivery system.

Alameda County's juvenile justice system is a component of a larger youth services delivery system. While juvenile justice is independent from public health, mental health, substance abuse, education, social services, housing, parks and recreation, community-based organizations, faith-based organizations, and neighborhood organizations, these components are interrelated. Although youth may be court-involved, often, many of these youth continue to be involved in other youth service systems. If one approaches youth services as a whole, without any boundaries, there is only one youth services delivery system operating in Alameda County[1]. This system can be strengthened and made more effective when stakeholders recognize their interdependence on one another and establish opportunities for collaboration and blending of resources.

The overall goals of this study were to analyze gaps in community-based services within Alameda County's juvenile justice system that result in youth being detained in the Juvenile Hall, to assess impediments in juvenile case processing that result in long detention stays and to develop strategies to reduce the number of youth detained in the Juvenile Hall.

The study was divided into two phases. During Phase I, eight Regional Juvenile Justice Roundtables were held in the following four regions of Alameda County:

Area 1: Oakland, Berkeley, Emeryville, Alameda, Piedmont
Area 2: San Leandro, San Lorenzo, Hayward, Castro Valley
Area 3: Union City, Newark, Fremont (Tri-cities)
Area 4: Dublin, Pleasanton, Sunol, Livermore (Valley)

The purpose of these roundtables was to identify the risk factors that contribute to juvenile crime in these communities.

Phase II involved comprehensive data collection, program analysis, research into best practices and evidence based programming in operation and evolving throughout California and the nation, and consideration of viable options for Alameda County, even in light of the dramatic budget restrictions facing the County.

Nearly 400 individuals were contacted during the course of this project through individual interviews, focus groups, roundtables, briefings and/or telephone surveys. Extensive data was collected with the assistance of various agencies and 30 databases were created. Interviews were conducted with stakeholders throughout the juvenile justice, educational, social services, behavioral health care, substance abuse services and health care systems and with community-based organizations, community advocates, and youth both involved in and outside the juvenile justice system. An analysis was conducted of the characteristics of the minors detained in the Juvenile Hall to determine if there was a potential pool of youth who could be considered for

[1] Senge, P.M. (1990). The Fifth Discipline: The Art & Practice of The Learning Organization. Currency and Doubleday.

alternatives to detention. The project team conducted a process and immediate impact evaluation of 46 delinquency prevention, early intervention, diversion, alternatives to detention, detention, probation, graduated sanctions, alternatives to placement, placement, and reentry services to minors involved in the juvenile justice system. A case processing analysis was conducted to determine policies and practices that impact on the length of time a minor is detained.

The following is the project team's key findings and preliminary recommendations. The team provides recommendations that are intended to enhance and reexamine existing policies, practices and programs to help make them more effective. A key goal in developing these recommendations was to expand service capacities without adding additional staff and additional General Fund revenues. Where recommendations require additional funds, preliminary suggestions are made for alternative funding sources. Proposals are presented to expedite juvenile cases through the juvenile justice process and to shorten minors' stay in the Juvenile Hall. New policies, practices and programs are suggested based on evidence-based models in use in California and throughout the nation.

New policies and practices are presented to expedite the juvenile's case through the juvenile justice process and to shorten the minor's stay in the Juvenile Hall. New policies, practices and programs are suggested based on evidence-based models in California and throughout the nation.

The project team suggests that these preliminary recommendations be presented to the Steering Committee to determine which recommendations are considered the most important and most feasible to implement immediately. Where appropriate, these recommendations will be refined and new recommendations may be developed for the Final Report, based on feedback from the Steering Committee.

## 1.1 Delinquency Prevention, Early Intervention and Diversion

### *Key Findings and Conclusions*

1. The Delinquency Prevention Network plays an important role in diverting at-risk youth from the juvenile justice system. If these services were not available, the project team believes that more youth would graduate to delinquent status. In particular, the 11 Youth Service Centers divert status offenders from intake. However, by design, they do not handle minors charged with misdemeanors and minor felonies. These youth are referred to juvenile intake where the majority of them (76.7%) are closed without any services and another 16.7% are placed on informal supervision where they receive little supervision. A study conducted by the Alameda County Probation Department in 1998 (latest data available), found that 50.8% of the cases closed at intake were later rearrested, in some cases, for more serious offenses. Other cases are formally processed but one-third of them are not filed on by the District Attorney.

2. Formal diversion programs for minors charged with minor 602 offenses are administered only in six police departments (Cities of Hayward, Berkeley, Fremont, Livermore, Piedmont and Pleasanton) and the Alameda County Sheriff's Office. With the elimination of Project First, the City of Oakland no longer has a formal diversion program. Youth in Oakland are either counseled and released or returned to their home without any support services from local agencies.

### *Preliminary Recommendations*

1. Every child referred to a delinquency prevention program should be screened using a standardized Risk, Needs and Responsivity assessment that identifies the youth's risk for

offending and the youth and the family's risk factors, needs and strengths to be addressed during the period of intervention. The Youth Level of Service Inventory-YLS/CMI, Global Appraisal of Individual Needs-GAIN, California Institute for Mental Health-Mental Health Screening Tool are examples to consider (see Appendices for descriptions of these assessment instruments). Long-term, these instruments should be validated on Alameda County's youth population. The Needs Assessment should be used to identify risk factors and problem domains in which further evaluation and a complete assessment should be conducted. Based on this assessment, the highest risk youth should receive the highest level of services because they pose the highest risk to the community and because they have the highest probability of becoming a delinquent. This practice should assist community-based organizations and the Probation Department to prioritize their resources.

2. Secondary assessments should be conducted by treatment providers qualified to conduct these assessments on those domains identified at intake as requiring further evaluation (California Institute for Mental Health-Mental Health Screening Tool, Adolescent Anger Rating Scale, State Trait Anger Expression Inventory, Beck's Depression Inventory, Comprehensive Addiction Severity Index for Adolescents (CASI-A) are examples of secondary assessments to consider). Secondary assessments should also be conducted to determine if the child is full scope Medi-Cal eligible for services to provide an additional source of funding.

3. Youth Service Centers located in the five locations in Alameda County that have the highest referrals to juvenile intake (e.g. Oakland, North County, South County, Tri-cities and the Valley) should be asked to serve as a Community Assessment, Referral and Diversion Center (CARD Centers) to address the following target populations:
   - Minors arrested on non-delinquent offenses
   - Minors arrested on misdemeanor offenses in lieu of filing a petition
   - Minors charged arrested on minor offenses (e.g. fighting at school, graffiti, petty theft, shoplifting, alcohol possession, marijuana possession, public intoxication, battery, vandalism) in lieu of filing a petition
   - Cases closed by Juvenile Intake

   These CARD Centers should collaborate with the County's Behavioral Health Care Services TEEN AOD Network of Alcohol and Drug Treatment providers and the Drug and Prevention Network.

4. The goal of this effort would be to reduce the number of referrals to Juvenile Probation Intake, reduce the number of cases to the District Attorney, provide intervention to cases that are high risk of reoffending and to reduce the number of youth sent to the Juvenile Hall. Additionally, this intervention should be aimed at increasing the protective factors within various communities to prevent further juvenile crime (note: intended to reduce the 50.8% rearrest rate of youth whose cases were closed at intake). See Appendices for examples of successful community-based referral services in San Diego, Orange County and San Francisco that resulted in reductions in the number of youth referred to Juvenile Intake and to the Juvenile Hall. This recommendation builds on the success of Youth Service Centers and the Diversion Programs in operation in Alameda County.

5. Evidence-based programs should be incorporated into programs implemented within the Delinquency Prevention Network (see Appendices for profiles of Evidence-based Model and Promising Programs).

6. Cognitive behavioral skills training (CBT) should be an integral component of all Delinquency Prevention programs, including but not limited to:
   - Reduction in criminal attitudes, thinking patterns and behavior
   - Violence reduction skills (conflict-resolution)
   - Decision-making skills

- Problem-solving skills

7. The Probation Department and community-based providers funded by TANF funds should continue to work toward a consensus on common performance measures that define the effectiveness of all delinquency prevention programs and then to develop specific performance measures for each program (YSC, CM and LSA). The same assessment instrument used at intake should also be used at discharge to document measurable change in the youth and their family as a result of the intervention. The project team has proposed *process, immediate and post-discharge performance measures* that could be used as a starting point. (see Chapter 8).

8. A Request for Proposal process should be developed by the Probation Department whereby community-based organizations are asked to develop their proposal for delinquency prevention assessment, services and diversion. This is customary when there are large sums of money to be distributed to a wide variety of agencies.

9. TANF funding should no longer be the sole source of funding for the Network. The Network should supplement these funds with alternative funding sources such as Title V: Community Prevention Grants Program of the Office of Juvenile Justice and Delinquency Prevention; Office of Justice Programs; Title IV-E; Medi-Cal; Early Periodic Screening, Diagnostic and Treatment (EPSDT); and Juvenile Mentoring Program (JUMP), Office of Juvenile Justice and Delinquency Prevention.

## 1.2 Case Processing

### *Key Findings and Conclusions*

1. Alameda County formally processes more juvenile cases from intake than nationally (99.8% formally processed by Juvenile Intake vs. 56.9% nationally), the District Attorney rejects 30.5% of the DPO's requests for petitions and 16.5% of final court dispositions result in informal probation suggesting that more cases could be handled informally and earlier in the process thus saving valuable court processing time.

2. The Profile Analysis of the minors in the Juvenile Hall indicated that the median time spent for a pre-adjudicated youth was 29-31 days and more than one-third of these minors were detained over 30 days (males spent an average of 54.3 days and females spent an average of 37.2 days). Post-adjudicated minors during this period of study (November 2003-February 2004) were detained a median of 50 days. While current databases show an overall (mean) stay of 22 days in the Juvenile Hall, these findings demonstrate that some minors stay much longer than this.

3. An analysis of the time between petition and the final court disposition (combined in and out of custody) indicated that the median days between these two steps is a median of 52 days.

4. In 2004, the population at the Juvenile Hall reached its functional capacity of 251 (90% of its design capacity) and to date, there is no on-going protocol developed to review this population on a weekly basis and to develop strategies to reduce it.

5. More than twenty percent (20.7%) of the youth detained have placement orders. These minors wait in a maximum-security bed until a group home bed opens up. These minors have already been determined to be suitable for community-based supervision, including attending their community school. It does not seem to be the best use of secure beds to keep these youth detained.

**6.** African-American youth are disproportionately represented at every stage of the juvenile justice process documenting that a higher priority needs to be given to address this issue throughout Alameda County. More than one-half of African-American youth are formally processed at each major stage of the case process and two-thirds of these youth are detained. On the other hand, African-American youth represent 17.2% of the youth population in Alameda County demonstrating that the African-American youth are disproportionately represented in the juvenile justice system. The Office of Juvenile Justice and Delinquency Prevention and the California Board of Corrections promotes policies that reduce d*isproportionate minority contact* within the juvenile justice system.

## ***Preliminary Recommendations***

1. The Juvenile Court, Juvenile Probation, District Attorney, Public Defender, and law enforcement agencies should reach consensus on a County-wide policy that defines the target population upon which Beat Officers are authorized to grant a Notice to Appear (NTA) in the field, upon which In-Custody Intake Deputy Probation Officers (DPO) at the Juvenile Hall are authorized to grant a NTA and which cases should be brought into custody based on the newly modified Risk Screening Instrument. The goal of this meeting (s) would be to develop general protocols that would guide the use of NTA and the Risk Screening Instrument.

2. The Juvenile Court, Intake DPOs, District Attorney, Public Defender and law enforcement officers should develop together a policy that provides the DPO criteria to use in determining which cases could be closed, counseled and released, referred for community-based services and placed on informal supervision at intake. The Intake staff should clarify with the District Attorney the type of cases to be referred for petitions given the high percentage of cases not petitioned by the DA. The protocol should also develop strategies that would enable DPOs to meet the 21-day deadline for filing cases with the District Attorney.

3. Intake DPOs should increase their referrals of minors charged with 601 and minor 602 offenses to Community Assessment, Referral and Diversion Centers (CARD Centers) in strategic locations throughout the County to enhance early intervention services to youth and families, to expand the use of informal supervision and diversion.

4. A system should be developed (either by mail or telephone) that notifies youth and families of court dates to reduce subsequent failure to appear (FTA's) and the issuance of warrants.

5. The Probation Department should implement a formal supervisory review of the cases of probation violators prior to the DPO initiating a violation hearing to ensure that all options have been exhausted prior to violating the minor.

6. Alameda County should reapply for grant funds to implement a Disproportionate Minority Contact initiative in order to reduce the number of African-American youth from the juvenile justice system. The Office of Juvenile Justice and Delinquency Prevention just released its 2005 funding plan that includes grant funds for this initiative.

7. Alameda County should develop an automated information system that permits all components of the Juvenile Court to access case-specific information, to send file information and electronic signatures via e-mail. The current system of transporting files from one office to another is inefficient, costly and it slows down the case handling process. Additionally, the MIS system should be HIPPA compliant and interface with other county departments and providers via a web-based secure system.

8. A Juvenile Hall staff member should be assigned to examine the detained population on a weekly basis, identify those cases that can are eligible for Electronic Monitoring, and expedite

the compilation of case information for detained minors. This case expediter would track detained cases through the juvenile case handling process, identify youth in detention who could be stepped down to an alternative to detention, and monitor minors awaiting placement thus reducing the length of stay at the Juvenile Hall.

Two examples of jurisdictions that have dramatically reduced their detention population through case processing are Sacramento, California and Cook County, Illinois.

Sacramento, CA created a Detention Early Resolution (DER) program to speed up the disposition of routine delinquency cases for juveniles assigned to the Detention Center and to an alternative to detention program. Five new procedures were implemented:

- Full discovery made at the outset of the case.
- A short form probation report is prepared within four days to guide decision-making.
- "Best plea bargain offers" are made immediately at the District Attorney's Office.
- A special case tracking system to assure coordination.
- Case conferencing prior to court appearances.

An Expediter was hired to track the cases and 75% of the detained cases are processed through the DER program. As a result of these reforms, the time from first court appearance to disposition has been reduced from 24 to 5 days and the detention population was reduced by 20%.

Cook County, IL implemented four new procedures to expedite cases through the system.

- Court notification program was implemented to remind defendants of pending court appearances to reduce the failure to appear warrants.
- Arraignment call was established which shortened the time between the issuance of the summons and the actual court appearance.
- Placement calendar was created to shorten the time for cases awaiting placement in residential facilities.
- Presumption against continuances

These procedures have resulted in reduced failures to appear, a reduction of the time between the issuance of the summons and actual court appearance from eight to two weeks, reduced continuances, and expedited placements.

In addition to these reforms, Cook County implemented a series of alternatives to detention such as evening reporting centers in various neighborhoods, outreach supervision, shelter care, home confinement/electronic monitoring, community service work program and a detention step-down program. These combined reforms have resulted in a 38% drop in the number of youth detained in the Cook County Temporary Detention Center from 1996-1999 (See Appendices for a summary of Cook County's Continuum of Detention Alternatives).

## 1.3 Alternatives to Juvenile Hall

### *Key Findings and Conclusions*

1. The Home Supervision and Electronic Monitoring programs are the only two formal alternatives to detention in Alameda County's juvenile justice system. Between 65%-81% of the youth participating in these options comply with their conditions indicating that these programs are evidence-based and effective. These have a high degree of impact on

managing the population at the Juvenile Hall since most minors in these options are pre-adjudicated and most of the minors detained are waiting their disposition hearings. However, these options are not yet fully maximized. Minors wait 2-3 weeks in detention to be evaluated.

## ***Preliminary Recommendations***

1. The Juvenile Hall staff should evaluate minors upon admission to the Juvenile Hall for Home Supervision and Electronic Monitoring. Formal criteria should be established for Home Supervision like there is for Electronic Monitoring. Instead of waiting for the second court date (2-3 weeks of confinement) to be evaluated for Electronic Monitoring, a minor should be evaluated for Electronic Monitoring as well as other alternatives and information verified within 72 hours after admission to the Juvenile Hall. The Juvenile Court, Probation Department and the District Attorney are recommended to develop a protocol to fully maximize this option.

2. Differential levels of supervision should be developed for Home Supervision and Electronic Monitoring to ensure that the highest risk minor receives the greatest intensity of supervision and services and the lowest risk minors receive fewer services. Given scarce staff resources, it will be important to develop differential levels of supervision.

3. A standard Risk and Needs Assessment instrument should be used for both the HS and the EM programs to ensure that the appropriate level intervention is provided.

4. A further evaluation should be conducted by the Probation Department, Juvenile Court, District Attorney and Public Defender to determine the number of minors who could be diverted to alternatives to detention in lieu of Juvenile Hall using the findings of this study as a starting point. This study found that 23% of the pre-adjudicated youth and 31% of the post-adjudicated minors could be considered for alternatives to detention.

5. The minors detained in the B2 Unit of the Juvenile Hall are recommended for evaluation and placement in a specialized Mental Health Wraparound Caseload in lieu of detention. A mechanism should be implemented to evaluate mentally ill youth upon admission to the Juvenile Hall to determine who might be eligible. Written criteria should be created with input from the Center for Behavioral Health Care Services, the Probation Department, District Attorney, Public Defender and the Juvenile Court Judge. The California Institute for Mental Health-Mental Health Screening Tool should be used to screen youth upon intake. Secondary assessments should be conducted later by Center for Behavioral Health Care Services on those domains identified at intake as requiring further evaluation (Global Assessment of Functioning (GAF), Adolescent Anger Rating Scale, State Trait Anger Expression Inventory, Beck's Depression Inventory, Comprehensive Addiction Severity Index for Adolescents (CASI-A) are examples of secondary assessments to consider). This caseload could be funded through a Blended Funding arrangement in which the Probation Department would have the case management funded by Medi-Cal funding through the Health Care Services Agency[2], by Systems of Care, Medi-Cal, EPSDT, Title IV-E, and the Juvenile Justice Crime Prevention Act.

6. A Memorandum of Understanding (MOU) should be established between the Juvenile Court, Probation Department, Health Care Services Agency and mental health treatment providers to provide these mental health wraparound services to these youth in their home while their case is being processed through the system. This is consistent with the Systems of Care initiative. Wraparound Milwaukee is an example of an evidence-based program that has

[2] Edelman, Susan. (1998). *Developing Blended Funding Programs for Children's Mental Health Care Systems: A Manual of Financial Strategies.* Cathie Wright Center for Technical Assistance to Children's Systems of Care.

reduced the out of home placement for non-violent mentally ill youth (see Appendices for description). If a child requires shelter, Malabar or other facilities should be considered.

7. A Day/Evening Reporting Center is recommended for non-violent pre-adjudicated minors and a portion of the minors held in the Juvenile Hall waiting placement provided they have a suitable home. Youth requiring short-term shelter should be referred to Malabar House or to another shelter while waiting for a community placement in lieu of the Juvenile Hall. Youth with community placement orders have already been determined by the Juvenile Court to be suitable for community-based programming and do not require confinement in a maximum-security bed. These programs should be geographically placed in three sites--at the Probation Offices in Oakland, Hayward and Fremont. Depending on the needs of the youth, there may or may not be school on site. Youth attending school should report to the DRC after school until 9:00 p.m. Youth who have been suspended, expelled or dropped out of school should attend from 9:00 a.m. until at least 5:30 p.m. Services should include education, tutoring, cognitive behavior change groups (CBT), substance abuse treatment, mental health counseling, family counseling and recreation. Participants would receive 1-2 meals depending on the length of their program.

   - An example of this type of program is in Chicago, IL. Six Evening Reporting Centers are located in high-crime neighborhoods and are designed to provide the court an alternative to secure detention. The target population are technical and minor offense probation violators, waiting for their violation hearings, who were previously detained in the Juvenile Detention Center. The program operates from 4:00 p.m.-9:00 p.m. and lasts up to 21 days. Youth are involved in educational activities, recreational programs and life skills training. Youth are transported to the center each evening, have a meal and participate in programming until 9:00 p.m. Probation Officers supervise the youth, conduct unannounced visits at the home and visit with the family at least weekly. The outcomes of the program indicate that 90% of the youth make their court hearings and remain arrest-free while in the program. An evaluation of the program found that 60% of the youth who participate would have been detained in secure detention if the program were not in operation. Sacramento, Orange County and Riverside County operate programs. These and other examples of evidenced-based programs are included in the Appendices.

   - An MOU with the Oakland Unified School District Community Day School should be established to refer non-violent youth who have been expelled from the Oakland schools to this CDS as an alternative to detention. This CDS has a capacity of 135 slots and it currently has 52 youth involved (October 14, 2004).

   - An MOU could be established with Pathways to Change for them to provide intensive, in-home case management services to youth involved in the DRC. This would provide an expanded target population for Pathways to Change and increase their client base.

   - An MOU could be established with the Alameda County Office of Education to work with the SB1095 agency partners to formally include these target populations in their programs.

   - These reporting centers could be funded through a variety of sources including, the Probation Department, Juvenile Justice Crime Prevention Act (JJCPA), 21st Century Community Learning Centers and the Independent Living Centers of the U.S. Department of Education; Blended Funding arrangements; Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Child Mental Health Service Initiative Project Grants, Child Adolescent and Family Branch, Division of Knowledge Development and Systems Change, Center for Mental Health Services; Center for Substance Abuse Treatment, Department of Health and Human Services, Demonstration Cooperative Agreement for Development and Implementation of Criminal

Justice Treatment Networks Project Grants: Division of Practice and Systems Development, Center for Substance Abuse Treatment, Department of Health and Human Services, Title IV-E, Early Periodic Screening, Diagnostic and Treatment (EPSDT) providers, SB1095 providers.

- Minors in these day programs who require short-term housing while they wait for their placement facility to open up should be considered for Malabar House or for another shelter. Shelter beds are comparable to the group home the child is going to in lieu of a maximum-security bed.

8. To ensure on-going effectiveness and feedback to staff, performance measures for each alternative to detention should be formalized, monitored through an automated database and reported on monthly and quarterly. Chief Don Blevins is commended for initiating the development of performance measures for each division with the Department. This information will enable the Probation Department to routinely evaluate on-going effectiveness.

9. A pre and a post test should be conducted on every child involved in an alternative to detention to measure attitudes, thinking patterns and positive behavioral change.

## 1.4 Expanded Continuum of Community-Based Options in Lieu of Detention, Placement and CYA Commitment

### *Key Findings and Conclusions*

1. Alameda County's Probation Department operates an evidence-based program entitled Community Probation. Data provided by the Probation Department documents a reduction in reported drug and alcohol use, decrease in suspensions/expulsions and increase the employability by participants as of February 2004. However, the number of youth in Community Probation has declined since 2001.

2. Probation supervision is not guided by a standardized Risk, Needs and Responsivity Assessment instrument to ensure that offenders receive the level of supervision and treatment they need. A core element of effective programs is that services are matched with the youth/family's assessed risks, needs, strengths and learning styles.

3. Most general supervision Deputy Probation Officers do not make home visits.

4. Interviews with DPOs indicate that most of the youth's families require counseling but only 10%-15% are involved in counseling.

5. There is no formal cognitive behavioral skills training (CBT) provided to juveniles on probation to reduce their criminal attitudes, thinking patterns and behavior nor is there any pre and post-test measurements used to measure change in attitudes, thinking patterns and behavior of juvenile offenders on probation.

6. There is no formal mechanism in place at the Juvenile Hall to screen out mentally ill youth from detention for an alternative to detention, and the majority of these youth do not receive a full mental health assessment, written treatment plan or mental health treatment while they are detained. The profile of minors detained documented that 62.2% of the youth in detention had one psychiatric disorder and 60.9% of these had more two or more disorders.

7. The profile of minors in the Juvenile Hall indicated that 81.7% of the males and 74.1% of the females reported use of an illegal drug and sixty one percent reported use of alcohol documenting a significant need for substance abuse assessment and treatment. However,

very few minors detained or on probation receive substance abuse assessment or treatment and the twenty beds reserved for probation youth at Thunder Road are underutilized.

8. The California Offender Program Services is one of the few programs identified in Alameda County that teaches attitude and behavioral change. However, this program is so short in its duration that it is unrealistic to expect any long-term attitude and behavioral change.

9. CYA Parole and the Alameda County Probation Department provide overlapping supervision. In some instances, officers from the two agencies supervise minors in the same family at the same time thus resulting in redundancies.

10. The Center for Behavioral Health operates an evidence-based Sex Offender Treatment Program but it is underutilized by the Probation Department.

11. The Independent Living Skills Program is a valuable service for youth aging out of probation but it is underutilized by the Probation Department.

## ***Preliminary Recommendations***

1. The Probation Department should conduct a Risk, Needs and Responsivity assessment at intake using an objective and standardized assessment instrument designed to assess the youth's risk for reoffending and needs to be addressed in the Case Plan. The information and scores from this assessment should be summarized in the PSI for the Juvenile Court to consider at the dispositional hearing. The Youth Level of Service Inventory-YLS/CMI, Youth Assessment Screening Instrument (YASI) and the Global Appraisal of Individual Needs-GAIN are examples to consider. These instruments have been validated on males, females, whites and non-whites. Eventually, these assessments should be validated on the youth population within Alameda County. The results of this instrument should be used for five overall purposes:
   - Information and scores should be used to develop a Case Plan for each youth.
   - Information from the assessment should be incorporated into the report to the Juvenile Court at the Dispositional Hearing so the Judge has information from various sources upon which to make a decision.
   - Findings from the assessment should determine the level of supervision required.
   - At discharge from probation, the instrument should be used to measure reduction in risk and need and to measure change in criminal attitudes, thinking patterns and behavior.
   - Based on this initial assessment, a case classification system should be established to determine the needed supervision level. The highest risk youth should be assigned to an intensive caseload whereby they receive the highest level of services because they have the highest probability of reoffending if intensive services are not provided. The lowest risk offender should be placed on a caseload that provides minimal services.

2. When problem areas are identified during the investigation stage that need further evaluation, the DPO should refer these youth to qualified treatment providers for secondary assessments (Global Assessment of Functioning (GAF), Adolescent Anger Rating Scale, State Trait Anger Expression Inventory, Beck's Depression Inventory, Comprehensive Addiction Severity Index for Adolescents (CASI-A) are examples of secondary assessments to consider).

3. The Probation Department should establish Counseling and Education Centers for youth on Informal Supervision and for those closed by the DPO at Juvenile Intake. Section 654 c of the Welfare & Institutions Code authorizes the probation department to maintain and operate "Counseling and Educational Centers" or to contract with private or public agencies to provide services in lieu of filing a petition to declare a minor a dependent child of the court. This recommendation could be in collaboration with the Community Assessment Referral Diversion Centers (CARD Centers). The level and type of services provided to youth on

Informal Supervision should be driven by the assessment and the highest risk youth should receive the highest level of services and minimal services should be provided to the lowest risk. The case of the lowest risk offender should be either closed or placed on a caseload that receives minimal services.

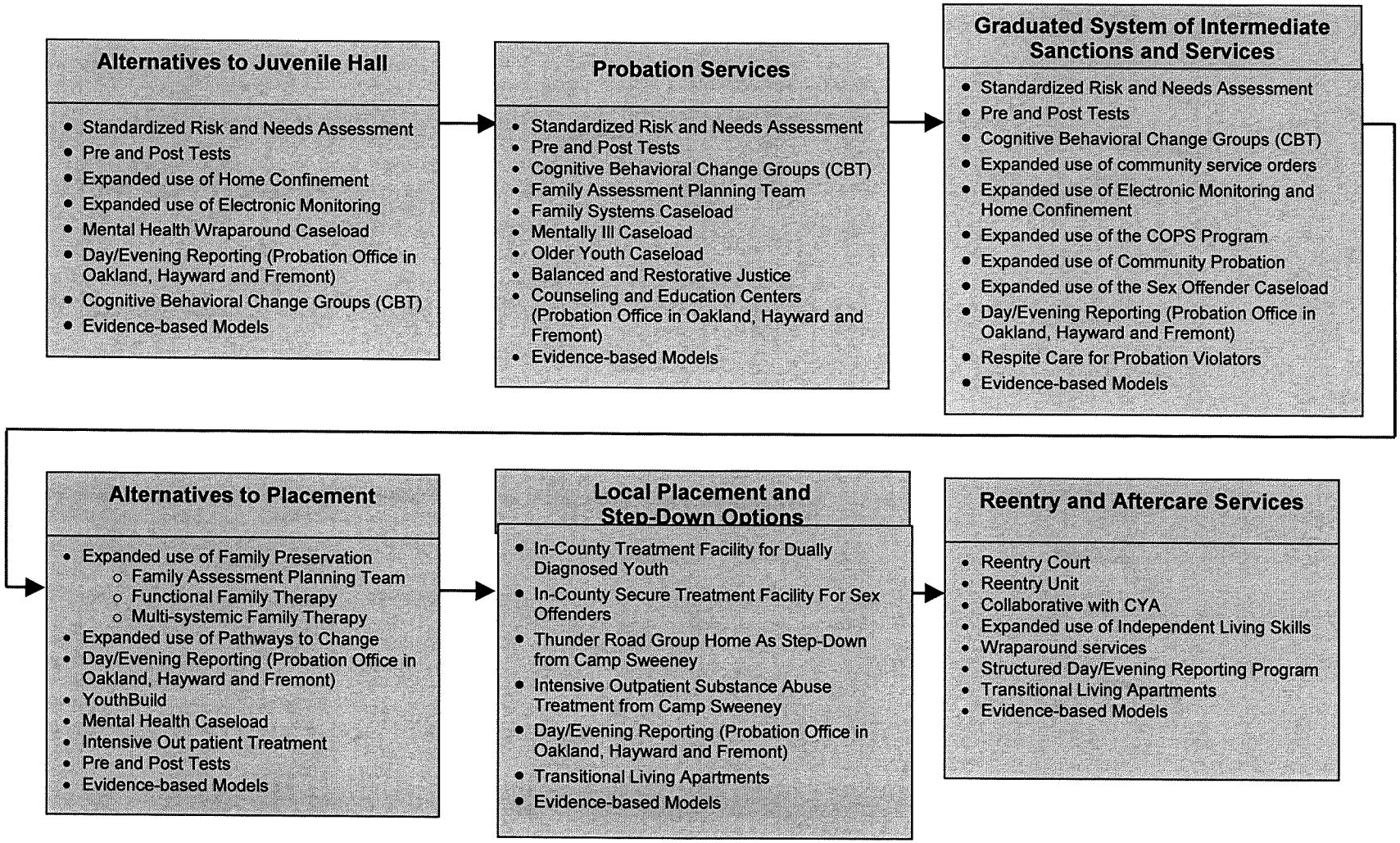
4. A Graduated System of Intermediate Sanctions and Services is recommended to reduce the number of probation violators confined in the Juvenile Hall, Camp Sweeney and sent to placement. Examples include:
   - Expanded use of community service orders: Findings indicate that this sanction is underutilized. Agencies receiving the service would provide on-site supervision. It is our understanding that the Weekend Academy Program has been reinstated.
   - Expanded use of Electronic Monitoring and Home Confinement.
   - Expanded use of the COPS program: Incorporate additional cognitive behavioral skills training and increase the length of these group sessions. See Appendices for examples of Cognitive Behavioral Training Resources. This is at no cost to the Probation Department.
   - Structured Day/Evening Reporting is recommended to be established in the Probation offices in Oakland, Hayward and Fremont. The target population for this program is youth who score moderate risk on the Risk and Needs Assessment and who can live in their own home or in a foster home. Those youth attending school should report to the DRC after school until 9:00 p.m. Youth who have been suspended, expelled or dropped out of school should attend from 9:00 a.m. until at least 5:30 p.m. Services would include education, tutoring, cognitive behavior change groups (CBT), substance abuse treatment, mental health counseling, family counseling and recreation. Either 1-2 meals are provided depending on the length of the youth's program. While the minor is participating, it is recommended that a structured parenting and family counseling program be conducted for parents of these youth. See Appendices for examples of Day Reporting Programs in Sacramento, San Diego, Orange and , Riverside Counties and in other states.
   - These Day/Evening Reporting Centers could be funded through a variety of sources including, the Juvenile Justice Crime Prevention Act (JJCPA), the Substance Abuse Treatment Network of the Office of Program Support, Substance Abuse and Mental Health Services Administration, Public Health Service, Department of Health and Human Services, Title IV-E, Medi-Cal, Early Periodic Screening, Diagnostic and Treatment and ACOE.
   - Expanded use of Community Probation for moderate to high risk probationers.
   - Expanded use of the Sex Offender Caseload provided by the Center for Behavioral Health Care Services.
   - The Probation Department should create a Family Systems Caseload consisting of adults and juveniles who are on Probation Supervision at the same time with the Alameda County Probation Department. Evidence-based family therapy models (see Chapter 16 Appendices) should be considered. A Memorandum of Agreement between the Probation Department and the Health Care Services Agency could be established whereby the therapist and the Case Manager could be funded under the Systems of Care Program.
   - The Juvenile Court should consider mandating that parents participate in the treatment plan of their child on probation and participate in parenting skills or counseling if the treatment plan identifies these needs to be addressed.
   - The Probation Department should establish a specialized caseload for the Mentally Il Offender (MIO Caseload) on probation and enter into MOUs with Health Care Services Agency and EPSTD providers to provide mental health services to youth and their families. Similar successful approach is in operation in Santa Barbara, CA and Wraparound Milwaukee. (See *Perspectives, Summer 2004. American Probation and Parole Association, re mental health service delivery systems for juvenile probation).*
   - The Probation Department should establish a specialized caseload for Older Youth aging out of the juvenile justice system. Services should be coordinated with the Independent

Living Skills Program to develop an Emancipation Plan and to recruit and coordinate services for these youth.

- The Probation Department should establish a Respite Facility for probation violators who require short-term shelter (1-2 days) in lieu of using the Juvenile Hall. Discussions should be initiated with Malabar House and other shelters to develop this option.

5. The following diagram summarizes the project team's recommendations for community based polices, practices and programs for court-involved minors. It includes recommendations for making greater use of existing partnerships between the Probation Department, Health Care Services Agency, Behavioral Health Care Services, Social Services Agency, County Office of Education; School Districts with Community Day Schools; SB1095 service providers; Workforce Investment, Pathways to Change; expanding existing programs; and developing new policies, practices and programs to enhance Alameda County's Juvenile Justice Continuum.

# Figure 1.1
## Summary of Recommendations
## Proposed Alternatives to Detention, Placement and CYA Commitment for Court-Involved Minors



A variety of funding arrangements and funding sources can be explored to fund these recommendations including:

- *Blended Funding* arrangements in which the Probation Department could have case management services, family therapy and behavioral health (CBT) funded by Medi-Cal funding through the Health Care Services Agency, Title IV-E, Family Preservation and Support Services, Administration for Children and Families through the Social Services Agency or with Alcohol and Other Drug Providers through Early Periodic Screening, Diagnostic and Treatment(EPSDT) funding
- *Memorandum of Understanding* with Pathways to Change, ACOE, Independent Living Skills Program, or Behavioral Health Care Services
- *Juvenile Justice Crime Prevention Act (JJCPA)*
- *Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances*, Child Mental Health Service Initiative Project Grants Child Adolescent and Family Branch, Division of Knowledge Development and Systems Change, Center for Mental Health Services
- *Substance abuse assessment and treatment,* Center for Substance Abuse Treatment, Department of Health and Human Services, Demonstration Cooperative Agreement for Development and Implementation of Criminal Justice Treatment Networks Project Grants: Division of Practice and Systems Development, Center for Substance Abuse Treatment, Department of Health and Human Services, the Substance Abuse Treatment Network of the Office of Program Support, Substance Abuse and Mental Health Services Administration, Public Health Service, Department of Health and Human Services
- *Juvenile Mentoring Program (JUMP)*, Office of Juvenile Justice and Delinquency Prevention.
- *Mentoring Children of Prisoners* of Section 439 of the Social Security Act.
- *Transitional Living Program* of the Family and Youth Services Bureau (FYSB), Administration for Children and Families, Department of Health and Human Services.
- *Shelter Plus Care (S + C)* program of the U.S. Department of Housing and Urban Development, Office of Community Planning and Development Department of Housing and Urban Development for *Transitional Living.*
- *21st Century Community Learning Centers* of the U.S. Department of Education.
- *Independent Living Centers* of Title VII of the Rehabilitative Act.

6. A core curriculum of CBT groups based on youth's assessed needs in Alameda County should be developed and provided, either through contracts with community-based providers or in conjunction with the Probation Department to reduce criminal attitudes, thinking patterns and behavior and to increase skills. Recommendations include but are not limited to:
   - Conflict Resolution/ Violence Reduction
   - Anger Management
   - Decision-Making
   - Healthy Relationships
   - Social and Communication Skills

7. The Probation Department should incorporate the principles of *Balanced and Restorative Justice*[3] into their mission statement and in practice. The Administrative Office of the Courts and California State Association of Counties, *Probation Services Task Force Final Report* , (2003), *Balanced and Restorative Justice* serves as a framework for balancing the needs of the offender, family, victim and community. The *community justice approach* promotes "*offender accountability, victim restoration, competency development and community collaboration."*

[3] American Probation and Parole Association. (1998). *Community Justice Concepts and Strategies.*

8. Community Probation is an evidenced-based program in Alameda County. It demonstrates the value of wraparound case management with partnerships with local agencies. This program should be more fully maximized and expanded.

9. Since placement facilities for dual diagnosed youth are not available in the County and are difficult to locate out of County, the Juvenile Court, Probation, treatment providers and the County should establish a secure residential treatment facility for youth who are both mentally ill and substance abusers, both mentally ill and a sex offender and for sex offenders. The John George Psychiatric Pavilion could be considered for this program.

10. The Probation Department is in the process of developing performance measures for each of its divisions. We support this effort. Additionally, youth should be assessed at midpoint and at discharge to probation to measure positive behavioral change. Probationers should be tracked 6, 12 and 18 months following discharge similar to what is done in Community Probation.

## 1.4 Juvenile Hall

### *Key Findings and Conclusions*

1. Every child who leaves the Juvenile Hall does not leave with a completed educational, pre-vocational (if older youth), mental health care, substance abuse, reentry assessment and written. National and state standards emphasize the importance of screening, assessment, and a Service Plan conducted.

2. The Juvenile Hall has implemented programs for some housing units but these programs are not available consistently in all housing units.

3. There is no core therapeutic program for all minors detained that addresses their mental health and substance abuse needs nor is there any cognitive behavioral skills development programs (CBT) provided for the detained population. There is no staff person who dedicates at least fifty percent of their time to develop and coordinate therapeutic and reentry programs for minors at the Juvenile Hall.

4. Juvenile Hall officials and the Center for Behavioral Health Care Services are commended for establishing a Special Housing Unit for mentally ill youth but this represents only 8.2% of the overall Juvenile Hall population. The Profile Analysis described in Chapter 5 documents that 62.2% of the detained youth had a psychiatric disorder and 60.9% of these had two or more diagnoses. These findings illustrate that the majority of minors with psychiatric disorders do not receive a complete mental health assessment or Treatment Plan nor do they receive treatment prior to their release.

5. Substance abuse education and a treatment group are provided only to minors housed in the B2 unit and in the Girl's Unit. Two staff from Thunder Road, Inc., a qualified substance abuse provider, conducts a one-hour group once a week to less than 9% of the minors detained. Most of the minors with substance abuse problems do not have complete assessments or treatment plans to guide their continuing treatment upon release.

6. The project team believes that the Juvenile Hall could do so much more for the youth detained and to prepare them and their families to face the next stage in the juvenile justice process. The Juvenile Hall is the feeder system for probation, Camp Sweeney, placement, and California Youth Authority. The time a minor stays in the Juvenile Hall could expedite the process of behavioral change.

## ***Preliminary Recommendations***

1. To supplement the Department's Risk Assessment currently under development, the current internally-developed Needs Assessment instrument should be replaced with a standardized Needs Assessment instrument (GAINS, MAYSI, POSIT are examples to consider-see Appendices). This Needs Assessment should be validated on youth at the Juvenile hall. This Needs Assessment should be used to identify problem domains in which further evaluation and complete assessment should be conducted. An assessment to determine if the child is full scope Medi-Cal should be conducted by the DPO. The assessment is recommended to be used in the following ways:
   - Development of an objective classification system that helps intake staff determine objectively to which housing unit the minor should be assigned.
   - Identification of needs that need further evaluation.
   - Specific counseling and pre-treatment groups to be developed within the Juvenile Hall.
   - Development of a Service and a Reentry Plan.

2. Secondary assessments using standardized instruments are recommended on those domains identified at intake as requiring further evaluation (California Institute for Mental Health-Mental Health Screening Tool, Adolescent Anger Rating Scale, State Trait Anger Expression Inventory, Beck's Depression Inventory, Comprehensive Addiction Severity Index for Adolescents (CASI-A) are examples of secondary assessments to consider).

3. Prior to discharge, each minor should have a written Educational Plan that includes pre-vocational goals for the older minor, a Health Care Plan that includes a Mental Health Treatment Plan and a Substance Abuse Treatment Plan that guides the next stage of intervention upon release.

4. A core substance abuse program should contain but not be limited to the following components: a more detailed intake screening instrument; secondary assessments where indicated by the intake screening, a written intervention plan, a written reentry plan, substance abuse education, substance abuse pre-treatment groups to prepare youth for treatment upon release and individual sessions as needed. Substance abuse counseling groups should be expanded to other housing units within the Juvenile Hall.

5. A core mental health services program should include but not be limited to the following components: a more detailed intake screening instrument approved by the Center for Behavioral Health Care Services and the Juvenile Hall intake staff, a secondary assessment for more youth where indicated by the intake screening, a written intervention plan, a written reentry plan, cognitive behavioral groups and individual sessions as needed. Mental health care individual and group counseling should be expanded in the Juvenile Hall to those assessed as needing these services.

6. A core program of cognitive behavioral change group sessions should be developed for and provided to all minors detained giving higher priority to changing minors' criminal attitudes, thinking patterns and behaviors. Core elements for this would include but not be limited to the following components: violence reduction, anger management, victim awareness, pro-social values, attitudes and thinking patterns, decision-making and problem solving skills). This Core Program is detailed in California Board of Corrections Standards (Title 15: Section 1370), in American Correctional Standards for Juvenile Detention Centers and the policies of the National Juvenile Detention Association. The specific areas to be addressed in the Core Program should be based on the results of the Needs Assessment. See Appendices for Cognitive Behavioral Training Resources to consider.

7. After the core program is developed, one staff member should be designated to recruit mentors, student interns and Foster Grandparents to provide services to more housing units. Local businesses should be recruited to give presentations to minors at the JH and Camp Sweeney to expose minors to multi-cultural employers who operate successful businesses. Foster Grandparents can be funded through the National Senior Service Corps, Foster Grandparent Program, Corporation for National and Community Service and Mentors can be funded through the Juvenile Mentoring Program of the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs.

8. To enhance the skills of Juvenile Counselors, to expand the number of programs at the Juvenile Hall, and to reduce downtime in the facility after school, Juvenile Counselors should be trained to co-facilitate with outside contractors or facilitate cognitive behavioral change groups (Juvenile Counselors at juvenile facilities in Texas and in Cook County, IL Juvenile Detention Center are examples of jurisdictions that include these tasks in their job classification for Juvenile Counselors). All counselors at Juvenile Hall and Camp should receive training in managing the youth offender population in a therapeutic manner. It is important that these Juvenile Counselors interact with the youth in a positive and supportive manner. This proposal should be discussed with and approved by the Juvenile Counselor Union.

9. The James King Fund, Temporary Assistance for Needy Families and Medi-Cal are potential funding sources to compensate staff and to purchase training programs and materials for youth confined in the Juvenile Hall. As is done in other jurisdictions throughout California, TANF funding should be explored for the Juvenile Hall to conduct mental health assessments, mental health treatment, substance abuse assessments, education and pre-treatment groups, and cognitive behavioral change programs to youth confined in the Juvenile Hall.

10. Prior to discharge, every child should have a Reentry Plan and staff should be given appropriate time to prepare the Reentry portfolio so that every child who is discharged has a plan. The Probation Department and the Juvenile Court should work together on developing a coordinated reentry protocol.

11. An automated information system should be created so that Juvenile Hall staff, teachers, health and mental health staff can transfer needed information electronically about the child in detention.

### 1.4.1 Juvenile Hall Education

1. Minors held in Units 3, 4 and B2 should be evaluated to determine if they are eligible to receive a post-test on the Advantage STAR Renaissance Test in Reading and Math.

2. A Career Interest Inventory should be conducted on older minors housed in Unit D to assist them with identifying their career interests. A standardized assessment instrument (e.g. PLATO, Career Interest Inventory are examples to consider). See Appendices for examples of career interest inventory assessment instruments.

3. Prior to discharge, each minor should have a written Educational Plan with specific reentry educational and employment goals (for the older minor) to guide them upon release.

4. Students should be exposed to the work-place literacy skills curriculum identified in the Secretary's Commission of Achieving Necessary Skills (SCANS)[4]. The project team believes this skills-based program would augment the Community Based Literacy program. SCANS is

[4] What Work Requires of Schools: A SCANS Report for America 2000, from the Secretary's Commission on Achieving Necessary Skills (SCANS). U.S. Department of Labor, June 1991.

recommended by juvenile correctional educators associated with the Workforce Investment Act and the Correctional Educational Association for students who may not return to school but who will enter the workplace. The SCANS focuses on pre-vocational preparation. It is based on a Three-part Foundation of 1) basic skills, 2) thinking skills and 3) personal qualities. Within this framework, it specifically teaches five workplace competencies that will be expected of persons entering the workforce including:

- Ability to maximize existing resources to one's benefit
- Ability to work well with others and control one's anger in the workplace
- Ability to acquire and evaluate data to present one's ideas
- Ability to understand social organizations and how they work
- Ability to identify and apply technology (See Appendix for further information).

5. A job readiness skills training program should be provided for older minors housed in Unit D to expose them to various trades and careers, to generate interest in the workplace, to prepare oneself for a job, to write winning resumes, and more importantly, to acquire the social, communication and emotional skills to retain a job. The Probation Department should collaborate with the Workforce Investment Board and ACOE to develop this pre-vocational skills training. The Magellan Curriculum, a self-directed, work-related assessment software program of the VALPAR Corporation and PLATO are current curriculum that could be considered. A job readiness classroom needs to be carefully designed.

6. A program of GED preparation and testing should be provided at the Juvenile Hall for the older unit housed in Unit D. A GED preparation classroom needs to be carefully designed.

7. An after-school program that includes homework and tutoring should be established in those times that minors are not in school. Juvenile Counselors and volunteers should assist minors with their homework. The project team believes that not requiring youth to complete homework sends a negative message to students. Students receive homework in their community school and they should be expected to complete homework while within the Juvenile Hall. Since The Beat Within has been successful in incorporating writing activities, the project team believes homework could be successfully monitored by Juvenile Hall staff as well. Interviews with Juvenile Hall staff indicated some interest in piloting this activity in the evening. The job description of the Juvenile Counselor should be amended to include their involvement in after-school programming.

8. Cognitive skills education such as anger management, problem-solving, decision-making, communications skills training should be developed with the Probation Department through an after-school program or during the school day. The list of cognitive skills is identified in Title XV of the Welfare and Institutions Code.

9. A Health Center for minors confined in the Juvenile Hall and Camp Sweeney is recommended. Currently, there are 11 Health Centers located in five school districts but none currently serving Juvenile Court Schools or those youth on probation. The target population for the SBHC is youth engaged in high risk sexual and health behaviors, which makes students attending the Juvenile Court Schools eligible. The overall mission of the SBHC is early screening, intervention and health education to teach vulnerable populations who do not have regular access to health care, how to avoid unwanted pregnancies and unhealthy behaviors that could lead to serious health consequences, such sexually transmitted diseases. Juvenile Court School students are the highest risk for unwanted pregnancies and disease, they clearly meet the criteria of the SBHC and these minors should have access to the same services as non-court-involved youth. Services provided by these Centers include medical, mental health and health education services such as:
   - Health education
   - Counseling, psychological and social services (8-32 hours each week)

- Physical education
- Health services
- Nutrition services
- Parent/community involvement
- Health promotion for staff

10. The Local Service Area Programs located in schools and Health Centers should examine the services provided by each of the programs and develop a coordinated plan to ensure that these two programs complement one another rather than duplicate services.

## 1.5 Camp Wilmont Sweeney

### *Key Findings and Conclusions*

Outcome data analyzed on Camp Sweeney participants during 2001-3004 document that only 10% of the minors successfully complete this Camp program and between 9.4%-12.7% of the minors do not return from their authorized furloughs.

The gaps in the program are:

- Comprehensive assessments that guide specific educational, vocational, psycho-educational or treatment programming
- Vocational education
- Family engagement
- Sufficient capacity for substance abusing youth
- Adequate prerelease planning-reentry planning that begins upon admission-instead it is begun in the last 2-3 weeks of the youth's stay at the Camp
- Educational transition for youth being released before 90 days-only youth who remain in the Camp for 90 days are eligible for the Transitional High Risk Program (SB1095)
- Seamless transition from Camp to continuing aftercare and support services following discharge (Note: The Probation Department has recognized this need and is developing a formal aftercare program).
- Aftercare component that allows youth "booster sessions"

These findings indicate that the current Camp Sweeney program is not effective since ten percent successfully complete the program. Likewise, there is no evidence of the impact of this program on reducing future recidivism following discharge 6, 12 and 18 months after discharge.

### *Preliminary Recommendations*

1. The Camp's mission, overall goals and program should be modified to provide the Juvenile Court an intermediate sanction for probation violators, for minors not suitable for group home placement and for minors who do not need to be committed to the California Youth Authority. The Camp should be considered as a graduated sanction and be considered for minors who fail other probation supervision options and placement. In this model, minors would receive all services at the Camp and not be permitted to go home for furlough until the last few weeks prior to release. The length of time spent at the Camp is recommended to be "competency-driven" based on youth's achieving specific program goals. This may mean that the minor is at the Camp longer in order to accomplish all treatment goals and positive behavioral change. Attitude and behavioral change should be measured by a pre test at admission and a post test at discharge using a standardized assessment instrument.
2. The specific type of program for each youth should be based on the assessment of risk and needs and the development of a case plan. See Appendices for examples of the Camp

Programs in other California jurisdictions. A Core Program should be developed for youth participating in the Camp. Suggestions include but are not limited to:

- Vocational program based on skills needed in demand in the area
- Job readiness skills
- Presentations by local employers and mock interviews
- Substance abuse education and treatment groups for chronic alcohol, drug and nicotine users
- Individual and group counseling
- Family relationships group
- Trauma and grief group
- Cognitive behavioral change groups (criminal thinking errors, violence reduction, conflict resolution, decision-making, problem-solving) Camp Sweeny youth should complete a curriculum based cognitive behavioral change group prior to release and connected with community based services prior to release.
- Family engagement (parenting skills and parent-child counseling groups)
- Parenting skills for the young men who are fathers
- Reentry planning that begins at intake
- Independent Living Skills Plan for youth 17-18 years of age who will live on their own
- Written Reentry Plan
- Restorative justice elements such as victim restitution, victim empathy training, victim awareness and community service
- Educational transition for youth being released from the Camp (only youth who remain in the Camp for 90 days are eligible for the Transitional High Risk Program (SB1095)

3. Develop a formal Reentry Aftercare program for minors discharged from the Camp. Examples of core components include but are not limited to:

- Relapse prevention groups at the Camp for once a week for six months
- Individual sessions as needed
- Volunteer mentors and Foster Grandparents: Foster Grandparents can be funded through the National Senior Service Corps, Foster Grandparent Program, Corporation for National and Community Service and Mentors can be funded through the Juvenile Mentoring Program of the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs.
- Facilitate the older youth into the Independent Living Skills Program
- Develop an MOU with Thunder Road's group home to step-down eligible youth from Camp Sweeney to residential substance abuse treatment or to Intensive Outpatient Treatment.
- As a step-down program for youth who have earned their release from Camp Sweeney, YouthBuild is recommended. This project works in conjunction with the Department of Housing and Urban Development and a local building contractor. The target population for this vocational education program is an older youth. The program provides an integrated program of education, pre-employment job training, leadership development, construction skills training, hands-on construction experience, life skills training, entrepreneurial skills training and social support

services. The hands-on construction experience should be provided through a partnership between a local building contractor and the YouthBuild program. This experiential training results in youth having real experience in building and selling affordable homes to low and moderate-income families. National data reported by YouthBuild USA indicates that 60.8% of the youth successfully complete and 85.2% are placed in jobs or school at the end of the program. This program is funded by YouthBuild USA.

4. Performance measures should be developed to evaluate the successful completion of programs while at the Camp, the achievement of treatment goals and the number of major and minor incidents at the Camp. An automated database should be implemented to track the performance of program goals and the minor should be tracked 6, 12 and 18 months following discharge from the Camp to measure rearrests and readjudications.

5. Residential treatment within the County for girls should be developed within the County either through contracts with treatment providers or by designating a portion of the Camp. An internal study is recommended to determine the number of girls who would be eligible for a secure residential program.

6. The Workforce Investment Act should be explored to fund vocational training, job readiness and job retention training. TANF and EPSDT should be explored to fund assessments and expanded counseling and MOU should be discussed with Alameda County Office of Education to provide psycho-educational groups at the Camp.

### 1.5.1 Camp Sweeney Educational Program

1. Every child who arrives at the Camp should have an educational assessment and an Educational Plan with specific educational goals developed while they were at the Juvenile Hall. The Camp DPO should assist in obtaining the Individual Education Plans from local school districts. It is not acceptable for teachers to wait 3-5 months to know students' needs and background.
2. The career interests and employability of older minors who are likely to enter the workplace upon release should be evaluated while at the Camp using standardized assessment instruments (PLATO, Career Interest Inventory are examples to consider). The SCANS curriculum should be incorporated into the curriculum for the older youth who will enter the workforce following discharge from the Camp.
3. A job readiness skills training program should be provided for older minors to expose them to various trades and careers, to generate interest in the workplace, to teach them the skills to locate employment, to prepare oneself for a job, to write winning resumes, and more importantly, to acquire the social, communication and emotional skills to retain a job. Career assessment, job readiness and job retention programming can be funded by the Workforce Investment Act.
4. The Camp administration and educational staff should ensure that the teachers have input into the Reentry Plan for each Camp student. The Reentry DPO should assist in the transition from the Camp Sweeney school and the child's next school by ensuring that school records are transferred within 72 hours upon discharge.
5. An automated information system should be created so that Camp staff, teachers, health and mental health staff can share needed information electronically about the child in the Camp.

## 1.6 Alternatives to Placement

### *Key Findings and Conclusions*

1. The Family Preservation Unit is not evidence-based, has little family involvement and has not achieved its goals of wraparound services.

2. Pathways to Change is a multi-systemic evidence-based program. This program is a valuable service provider but is underutilized by the Probation Department. Pathways to Change is an excellent example of an evidence-based, wraparound case management model that has demonstrated success. This agency is a valuable service provider for the County.

### *Preliminary Recommendations*

1. The Family Preservation Unit should be reexamined to increase its effectiveness. The FPU should establish a clear target population, clear goals, and performance measures to evaluate its success. By design, it is a wraparound model, but in the project team's opinion, it has not yet achieved its mission.
2. Youth should be placed into FPU if the risk and needs assessment indicates that they require this high level of supervision and monitoring. This assessment should be conducted by the Probation Department and presented to the Court prior to placement so that the Court has the best information available to it. Families' overall level of functioning should be assessed to determine if they require structured counseling.
3. Families involved in FPU should be offered family counseling and parenting skills training. See Appendices for successful evidence-based models—Functional Family Therapy and Multi-systemic Therapy. FFT involves between 8 and 30 hours of home-based therapy per week spread over a three-month time period. A team of probation and mental health staff delivers therapy. Outcome studies indicate that FFT can reduce the rate of reoffending and foster care and institutional placement by 25%-60%. The cost of this treatment service is $24.00 per day for 90 days. This program can be funded by OJJDP, National Institute of Drug Abuse, National Institute of Alcohol Abuse, Medicaid and TANF.

   Multi-systemic Therapy is an intensive wraparound program for serious, chronic delinquent probationers who are at-risk of out-of-home placement. A Multi-systemic Assessment Team should be formed to review each case, to conduct an assessment of the youth, family, peers, school, and neighborhood, the MST Team assigns a case manager to coordinate treatment and to report back to the Team twice a month. A caseload of no more than six families is recommended in order to provide intensive, in-home services to 20 hours each week and the length of the program should be five months. Eight evaluations of MST have substantiated a 47%-64% reduction in residential treatment, 25%-70% reduction in rates of rearrest, and improvements in family functioning in eight evaluations.

   The Probation Department and the Social Services Agency should reallocate some of the out-of-home placement funds currently being used for youth in placement to fund the Family Preservation Unit, FFT and the Multi-Systemic Therapy for serious offenders on probation as is done in other jurisdictions (Monroe County, IN). Since it is estimated that 50% of the minors on probation are full-scope Medi-Cal, funding should be explored from Family Preservation and Support Services, Administration for Children and Families; Medi-Cal; Title IV-E, TANF, and from EPSDT-approved providers for specialized services not offered by the Probation Department. The cost per youth is $55.00 per day.

4. An automated database should be created that monitors the outcomes of the cases on Family Preservation, tracks the youth discharged from FPU 6 and 12 months following discharge and provides monthly and quarterly reports on the outcome of the program.

5. Pathways to Change is a valuable service provider for the County. It will be even more effective if it deals with populations that are in need of intensive out-patient services, such as mentally ill and dually diagnosed (mentally ill and substance abusers). These youth are involved in more than one service delivery system and intensive outpatient services for these youth appear to be a gap within the County. This successful wraparound approach would augment traditional probation services and provide the Probation Department a service that it cannot currently provide given current resources. This program should be fully maximized by the Probation Department.

## 1.7 Reentry and Aftercare Services

### *Key Findings and Conclusions*

Reentry services for youth discharged from Juvenile Hall, from Camp Sweeney and placement facilities are not well-coordinated. The Alameda County Probation Department and CYA Parole have areas of overlapping interest, supervision and jurisdiction. In some instances, officers from the two agencies are supervising minors in the same family at the same time.

### *Preliminary Recommendations*

1. Alameda County should consider establishing a Reentry Court for youth coming out of CYA facilities to ensure that these youth comply with conditions and receive aftercare support to reduce their future rearrests and readjudications.

2. It is recommended that the Probation Department establish a Reentry Unit that would serve youth released from the following:
   - Placement (foster home, group home)
   - Camp Sweeney
   - Juvenile Hall
   - Additionally, if the proposed legislation is approved that would charge probation departments with the responsibility of reentry services for youth coming out of CYA facilities, this population should also be supervised by the Reentry Unit. Funding opportunities will open up from the proposed Second Chance Act if a formal unit was dedicated to reentry.
   - A Reentry Plan should be developed by the Reentry Unit prior to a minor being released from any facility. A Reentry Program should be developed to follow the youth six months following discharge from these facilities. A formal program of volunteer Mentors should be created to provide support to youth discharged from facilities. Mentors can be funded through the Juvenile Mentoring Program of the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs and the Mentoring Children of Prisoners of Section 439 of the Social Security Act. With a formalized aftercare program, the time spent in facilities could be reduced, costs for placement would be reduced, and it would expedite family reunification.

3. Thunder Road is an excellent resource to the Probation Department and one in which is being underutilized. Thunder Road's group home could serve as a transitional facility for youth coming out of Camp Sweeney and Intensive Outpatient services could serve as aftercare for youth who do not require housing.

4. The Probation Department should work together with the local CYA Parole office to reduce redundancies of supervision of those minors who are also under supervision by CYA Parole. Enhancing collaboration and communication between the two agencies is especially important in light of ongoing legislative and policy initiatives to transfer responsibility for supervising Youth Authority parolees to county probation departments.

5. Alameda County should expand its use of the Independent Living Skills Program for youth aging out of probation to provide needed life skills, employment, housing, health care and other transitional services to help prepare them for self-sufficient adulthood. To date, the ILSP is underutilized by the Probation Department for youth on probation. The ILSP could provide valuable community support services as well as support for DPO supervision, especially for those probationers approaching adulthood and/or emancipation.

6. Alameda County should also explore Transitional Living Apartments for older youth released from Camp Sweeney, Juvenile Hall and placement facilities such as those in operation in other states (Chicago, IL). These apartments are located in commercial/residential areas of the city. They either have 24-hour adult staff supervision on-site or provide a Supervision Team to youth in their own apartments. In Chicago, Kaleidoscope, a non-profit agency, has contracts with 65 apartments. Their staff of five provides 24-hour on call crisis support, the youth has a face-to-face contact with the staff twice a week and the youth receives $65.00 per week for supportive services. The program is supplemented by an Adolescent Parent Specialist for parenting training and a Housing Coordinator who finds the youth apartments. The cost is $107.77 per day ($38.00 is paid by Medicaid and $69.77 is paid by Title IV). These apartments can be funded by the *Transitional Living Program* of the Family and Youth Services Bureau (FYSB), Administration for Children and Families, Department of Health and Human Services; *Shelter Plus Care (S + C)* program of the U.S. Department of Housing and Urban Development, Office of Community Planning and Development Department of Housing and Urban Development.

7. The Probation Department should contact Representatives in Congress to indicate their support for the Responsible Reintegration of Youthful Offenders/ Reintegration of Youthful Offenders Program (S.2810). This funding mechanism targets youth returning to communities from correctional facilities, youth on probation as an alternative to correctional confinement, as a diversion from formal judicial proceedings and youth on parole as an alternative to return to incarceration and. This funding is proposed to provide support, education and training to youth in these targeted groups.

## 1.8 Other Recommendations

1. The project team recommends that an on-going mechanism be authorized to continue the discussions on juvenile justice reform and to develop Action Plans to implement some of the recommendations found within this report. This Council should include the key implementers of juvenile justice reform and invite community advocates, faith-based organizations, community-based organizations and youth to provide input on draft Action Plans to ensure that the plan is feasible and will be acceptable to their community.

2. After the Final Report and its recommendations are approved by the Alameda County Board of County Supervisors, a Staff and Community Education Plan should be developed and implemented to train staff and to inform community members of the recommendations. Staff education and training briefings/retreat, news releases, flyers, a standard power point presentation, focus groups, roundtables, website and public hearings should be considered as mechanisms to communicate Alameda County's Vision to staff and to the community.

3. During Phase I of this study, a number of key community leaders were identified. It is recommended that these be invited to participate in further discussions on juvenile justice reform and to solicit their support in developing and implementing specific Action Plans in

their communities. The following are community organizations that should be invited to lead reform efforts in their neighborhoods throughout Alameda County:

- Neighborhood Crime Prevention Councils
- Community Health Teams
- Youth Service Centers
- Faith-based organizations
- Health Centers
- Probation Satellite Offices
- League of Women Voters
- Youth organizations

4. To initiate contracts/Memorandum of Agreements with existing public and private agencies and to develop grants with funding agencies, the project team recommends the designation of an Administrative /Grants liaison in Alameda County.

5. Alameda County should further develop and implement a Youth Development Strategy that enhances the safety of communities so youth can grow and thrive, that promotes a community culture that values and supports youth, that strengthens their communities, that "provides them opportunities to contribute to their community, gain leadership skills, and ensures that youth have the opportunities to acquire and strengthen their sense of competence, usefulness, belonging and power—the four key principles of youth development"[5].

[5] National Clearinghouse on Families and Youth. July 1996. *Reconnecting Youth and Community: A Youth Development Approach.* U.S. Department of Healthy and Human Services, Administration for Children and Families.

# INSERT VOLUME 2A HERE

# *COMPREHENSIVE STUDY OF THE ALAMEDA COUNTY JUVENILE JUSTICE SYSTEM STEERING COMMITTEE*

Co-Chair Gail Steele
President, Board of Supervisors

Co-Chair, Carl Morris
Presiding Judge
Superior Court-150, District 2

- Diane A. Bellas, Public Defender, Alameda County Public Defender's Office
- Donald Blevins, Chief, Alameda County Probation Department
- Sally Bystroff, Community Advocate
- Tom Gerstel, Director, Thunder Road
- Carol Haberberger, Juvenile Hall, Special Education Teacher
- Chet P. Hewitt, Director, Alameda County Social Services Agency
- Sheila Jordan, Superintendent of Schools, Alameda County Office of Education
- David Kears, Director, Alameda County Health Care Services Agency
- Steve Krull, Chairman, Local Planning Council
- Donna Linton, Assistant County Administrator, Alameda County Administrator's Office
- Leonard Lloyd, Community Advocate
- Gilbert I. Martinez, Director, Integrated Counseling and Consulting Services
- Nate Miley, Supervisor, Board of Supervisors, District 4
- David Muhammad, Director, The Mentoring Center
- Susan Muranishi, County Administrator Alameda County Administrator's Office
- Carolyn Novosel, Director, Children and Youth Services Alameda County Health Care Services Agency
- Tom Orloff, District Attorney, Alameda County District Attorney's Office
- Irma Parker, Teacher, Berkeley High School
- Charles Plummer, Sheriff, Alameda County Sheriff's Department
- Susan Walsh, Deputy Public Defender
- Iris Winogrond, League of Women Voters, Community Advocate
- Richard Word, Chief of Police, Oakland Police Department, President, Alameda County Chiefs of Police and Sheriff's Association

# PROBATION

## PROBATION DEPARTMENT'S RESPONSE

**TO**

## COMPREHENSIVE STUDY OF THE JUVENILE JUSTICE SYSTEM REPORT AND RECOMMENDATIONS

*Presented By*

***Donald H. Blevins, Chief Probation Officer***

The report contains 8 sections with numbered recommendations in each section. Responses to the recommendations are presented using the corresponding numbering system in the report prepared by Huskey and Associates.

Responses are color-coded as follows:

| | |
|---|---|
| **Yellow** | **Current practice.** |
| **Blue** | **Short-term goal (1-2 years). Probation Department is lead agency.** |
| **Purple** | **Long-range goal. Probation Department is lead agency.** |
| **Green** | **Long-range goal. Probation Department is secondary partner to identify lead agency.** |

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## 1.1 DELINQUENCY PREVENTION, EARLY INTERVENTION & DIVERSION

1. Every child referred to a delinquency prevention program should be screened using a standardized Risk, Needs and Responsivity assessment that identifies the youth's risk for offending and the youth and the family's risk factors, needs and strengths to be addressed during the period of intervention.

| SERVICE PROVIDER | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Dr. James Austin/Contract Provider | Development of standardized risk / needs assessment tool | Juvenile Accountability Block Grant (JABG) |

2. Secondary assessments should be conducted by treatment providers qualified to conduct these assessments on those domains identified at intake as requiring further evaluation.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| YSA, CBOs | Secondary assessments, performed by treatment providers or referral to appropriate treatment provider (drug abuse, mental health, anger, depression, assessment tools | CYSA / EPSDT |

3. Youth Service Centers located in the five locations in Alameda County that have the highest referrals to juvenile intake should be asked to serve as a Community Assessment, Referral and Diversion Center (CARD Centers) to address the following target populations .

4. The goal of this effort would be to reduce the number of referrals to Juvenile Probation Intake, reduce the number of cases to the District Attorney, provide intervention to cases that are high risk of reoffending and to reduce the number of youth sent to the Juvenile Hall. Additionally, this intervention should be aimed at increasing the protective factors within various communities to prevent further juvenile crime (note: intended to reduce the 50.8% rearrest rate of youth whose cases were closed at intake). See Appendices for examples of successful community-based referral services in San Diego, Orange County and San Francisco that resulted in reductions in the number of youth referred to Juvenile Intake and to the Juvenile Hall. This recommendation builds on the success of Youth Service Centers and the Diversion Programs in operation in Alameda County.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, BHCS, SSA, PH & ACOE | Community Assessment Referral and Diversion Center (Card center) | Blended Funding Project |

5. Evidence-based programs should be incorporated into programs implemented within the Delinquency Prevention Network (see Appendices for profiles of Evidence-based Model and Promising Programs).

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Prevention Network | Common performance measurements for all CYSA Services and use of pre / post assessment instrument. | Blended Funding Project |

## 1.1 (continued)

6. Cognitive behavioral skills training (CBT) should be an integral component of all Delinquency Prevention programs.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, CBOs | Evidence-based program | TANF |

7. The Probation Department and community-based providers funded by TANF funds should continue to work toward a consensus on common performance measures that define the effectiveness of all delinquency prevention programs and then to develop specific performance measures for each program (YSC, CM and LSA).

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, CBOs | Cognitive Behavioral Skills Training | TANF |

8. A Request for Proposal process should be developed by the Probation Department whereby community-based organizations are asked to develop their proposal for delinquency prevention assessment, services and diversion.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, GSA | Upon development of assessment tool, RFP process will be developed for CYSA Providers. | CYSA (State Funding) |

9. TANF funding should no longer be the sole source of funding for the Network. The Network should supplement these funds with alternative funding sources.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Prevention Network, CBOs | Alternative Funding Streams | Title IV<br>EPSDT<br>Measure Y |

## 1.2 CASE PROCESSING

1. The Juvenile Court, Juvenile Probation, District Attorney, Public Defender, and law enforcement agencies should reach consensus on a County-wide policy that defines the target population upon which Beat Officers are authorized to grant a Notice to Appear (NTA) in the field, upon which In-Custody Intake Deputy Probation Officers (DPO) at the Juvenile Hall are authorized to grant a NTA and which cases should be brought into custody based on the newly modified Risk Screening Instrument.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Law Enforcement Agencies, DA, PD | The Juvenile Court, DA, PD and law enforcement will convene to develop policy for NTA's and detention screening (in process). | General Fund |

2. The Juvenile Court, Intake DPOs, District Attorney, Public Defender and law enforcement officers should develop together a policy that provides the DPO criteria to use in determining which cases could be closed, counseled and released, referred for community-based services and placed on informal supervision at intake.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, DA | Probation and DA will meet to discuss high percentage of cases not petitioned. | General Fund |

3. Intake DPOs should increase their referrals of minors charged with 601 and minor 602 offenses to Community Assessment, Referral and Diversion Centers (CARD Centers) in strategic locations throughout the County to enhance early intervention services to youth and families, to expand the use of informal supervision and diversion.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, BH, SSA, PH and ACOE | • A community assessment referral and Diversion Center (CARD) will be investigated with BH, SS, PH and ACOE<br>• The goal of the CARD center includes reducing the number of cases that go to DA / Probation / Juvenile Hall in addition to providing appropriate intervention for those at high risk of re-offending. | Blended Funding |

4. A system should be developed (either by mail or telephone) that notifies youth and families of court dates to reduce subsequent failure to appear (FTA's) and the issuance of warrants.

| SERVICE PROVIDER | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | An automated phone message system that notifies youth and family of court dates will be investigated. | Blended Funding |

## 1.2 (continued)

5. The Probation Department should implement a formal supervisory review of the cases of probation violators prior to the DPO initiating a violation hearing to ensure that all options have been exhausted prior to violating the minor.

| SERVICE PROVIDER | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Supervision review of probation violations | General Fund<br>Title IV-E |

6. Alameda County should reapply for grant funds to implement a Disproportionate Minority Contact initiative in order to reduce the number of African-American youth from the juvenile justice system.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Delinquency Prevention Network, ICPC | DMC initiative | Title V |

7. Alameda County should develop an automated information system that permits all components of the Juvenile Court to access case-specific information, to send file information and electronic signatures via e-mail.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Court | Probation has initiated RFP for automated information system. | General Fund |

8. A Juvenile Hall staff member should be assigned to examine the detained population on a weekly basis, identify those cases that can are eligible for Electronic Monitoring, and expedite the compilation of case information for detained minors.

| SERVICE PROVIDER | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Juvenile Hall caseworker duties include a system to expedite/ re-evaluate identified detainees at Juvenile Hall | Title IV-E |

# 1.3A ALTERNATIVES TO JUVENILE HALL

1. The Juvenile Hall staff should evaluate minors upon admission to the Juvenile Hall for Home Supervision and Electronic Monitoring. Formal criteria should be established for Home Supervision like there is for Electronic Monitoring.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation Department | Electronic Monitoring **-** In-home detention alternative monitoring | General Fund |
| Probation Department | Home Supervision - Daily home and school monitoring. | CYSA / General Fund / Title IV E |

2. Differential levels of supervision should be developed for Home Supervision and Electronic Monitoring to ensure that the highest risk minor receives the greatest intensity of supervision and services and the lowest risk minors receive fewer services.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation Department | Intensive supervision for all minors<br>• 1.10 ratio<br>• Daily client contact<br>• Daily school home report | General Fund |

3. A standard Risk and Needs Assessment instrument should be used for both the HS and the EM programs to ensure that the appropriate level intervention is provided.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation Department | Standardized Assessment Instrument | General Fund |

4. A standard Risk and Needs Assessment instrument should be used for both the HS and the EM programs to ensure that the appropriate level intervention is provided.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Courts, PD, DA | Screening per W & I Code for diversion from Juvenile Hall | General Fund |

5 The minors detained in the B2 Unit of the Juvenile Hall are recommended for evaluation and placement in a specialized Mental Health Wraparound Caseload in lieu of detention.

6. A Memorandum of Understanding (MOU) should be established between the Juvenile Court, Probation Department, Health Care Services Agency and mental health treatment providers to provide these mental health wraparound services to these youth in their home while their case is being processed through the system.

## 1.3A (continued)

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| The Juvenile Court, Health Services, Behavioral Health | Develop MOU with the Juvenile Court, Health Care Services, and mental health providers to provide wraparound services to youth during the time their case is being processed | Blended Funding |

7. A Day/Evening Reporting Center is recommended for non-violent pre-adjudicated minors and a portion of the minors held in the Juvenile Hall waiting placement provided they have a suitable home. Youth requiring short-term shelter should be referred to Malabar House or to another shelter while waiting for a community placement in lieu of the Juvenile Hall.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, ACOE, PH, BH | Transitional program (in-lieu of day/evening reporting, etc) | Blended Funding |

8. Performance measures for each alternative to detention should be formalized, monitored through an automated database and reported on monthly and quarterly.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Probation has initiated RFP for automated information system | Grants/General Fund |

9. A pre and a post test should be conducted on every child involved in an alternative to detention to measure attitudes, thinking patterns and positive behavioral change.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, primary providers | Pre/post testing | Grants |

# 1.3B EXPANDED CONTINUUM OF COMMUNITY-BASED OPTIONS IN LIEU OF DETENTION, PLACEMENT AND CYA COMMITMENT

1. The Probation Department should conduct a Risk, Needs and Responsivity assessment at intake using an objective and standardized assessment instrument designed to assess the youth's risk for reoffending and needs to be addressed in the Case Plan.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Dr. James Austin/ or private contract | Field Supervision will use results of primary and secondary needs assessment instruments to validate court approved Case Plan and client compliance with related terms and conditions of probation. | JBAG, TANF, JJCPA |

2. When problem areas are identified during the investigation stage that need further evaluation, the DPO should refer these youth to qualified treatment providers for secondary assessments.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Local Service Area Providers | Service Referrals for: academic tutoring and monitoring, counseling and treatment health care education and referral, financial planning strategies, job preparation and employment. | **General Fund/Grant** |

3. The Probation Department should establish Counseling and Education Centers for youth on Informal Supervision and for those closed by the DPO at Juvenile Intake.

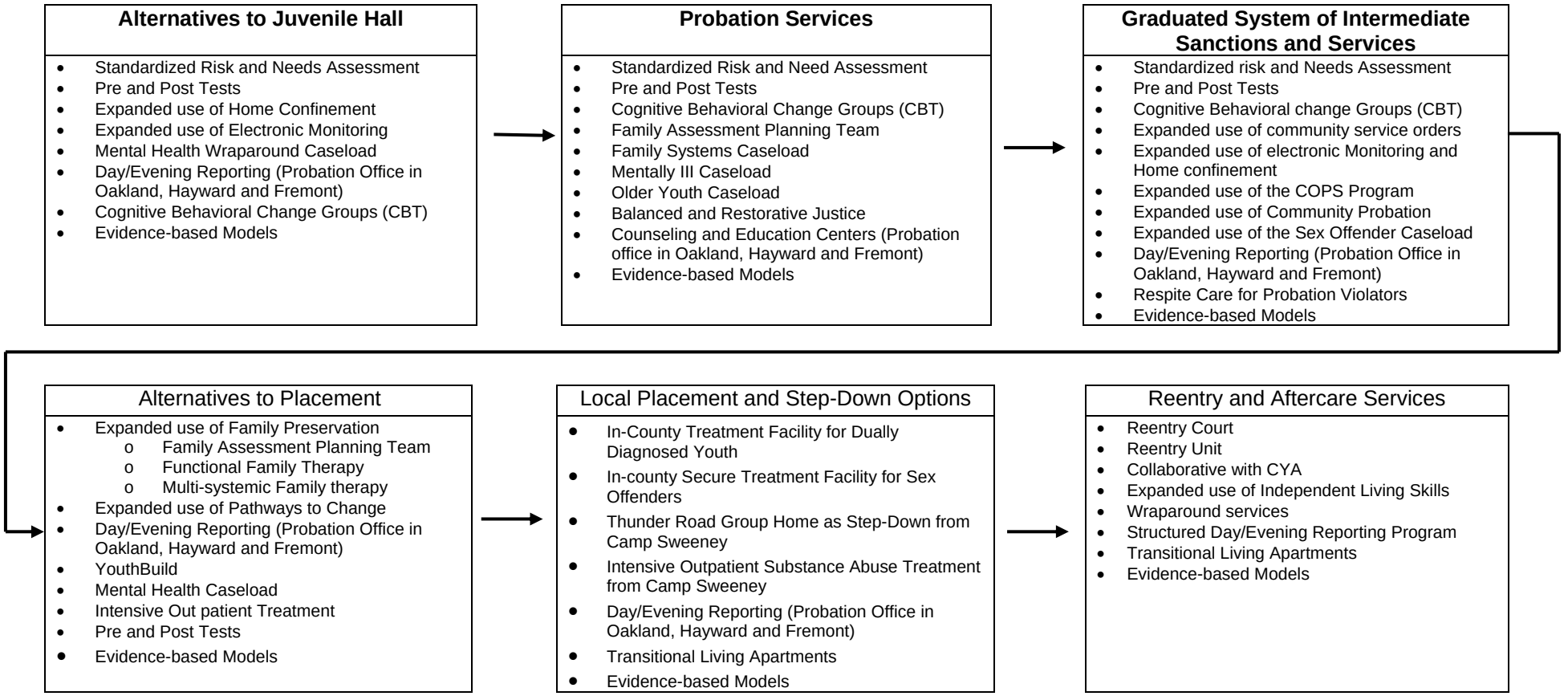
| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Youth Service Centers (11) | Family focused counseling for at-risk youth. | CYSA (State Funding) |
| Crisis Receiving Home (Malabar House) | Crisis shelter for incorrigible, runaway youth (601 W&I) | CYSA (State Funding) |
| School District / Health Centers / CBO's | Counseling (school-based), parenting, tutoring, life skills. | CYSA (State Funding) |
| McCullum Youth Court | • Alternative to Juvenile Court for 1st time offenders:<br>• Peer Court<br>• Community Service<br>• Individual Assessment | CYSA (State Funding) |
| Alameda County Probation Department Truancy Unit | Probation / District Attorney / Juvenile Court Collaborative that intervenes with truants referred by school district. (Assessment / referral, Diversion Services, SARB / Truancy Center support). | CYSA / General Fund/ DA / Court Funding |

## 1.3B (continued)

4. A Graduated System of Intermediate Sanctions and Services is recommended to reduce the number of probation violators confined in the Juvenile Hall, Camp Sweeney and sent to placement.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Weekend Training Academy | Community Service and citizenship Training | **CYSA** |
| Community Probation Program | Service Referrals for: academic tutoring and monitoring, counseling and treatment, health care education, and referral, financial planning strategies, job preparation and employment, recreational activities. Wrap-around service funds | **JJCPA Grant** |
| Probation, BHC | Expanded community based sex offender treatment services | **Blended funding** |

5. The following diagram summarizes the project team's recommendation for community based policies, practices and programs for court-involved minors.



## 1.3B (continued)

6. A core curriculum of CBT groups based on youth's assessed needs in Alameda County should be developed and provided, either through contracts with community-based providers or in conjunction with the Probation Department to reduce criminal attitudes, thinking patterns and behavior and to increase skills.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, CBOs | CBT Groups core curriculum for | JJCPA, TANF; General Fund, California Endowment |

7. The Probation Department should incorporate the principles of *Balanced and Restorative Justice*[1] into their mission statement and in practice.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Restorative Justice | General Fund |

8. Community Probation program should be more fully maximized and expanded.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, CBOs | Comprehensive intervention services | JJCPA |

9. The Juvenile Court, Probation, treatment providers and the County should establish a secure residential treatment facility for youth who are both mentally ill and substance abusers, both mentally ill and a sex offender and for sex offenders.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| BHCS, Juvenile Court | Residential dual diagnosis treatment for mentally ill, substance abusers. | Prop 63 |

10. Youth should be assessed at midpoint and at discharge to probation to measure positive behavioral change. Probationers should be tracked 6, 12 and 18 months following discharge similar to what is done in Community Probation.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | 6,12,18mo. Post-discharge assessments | General fund, Grants |

[1] American Probation and Parole Association. (1998). *Community Justice Concepts and Strategies.*

## 1.4 JUVENILE HALL

1. The current internally-developed Needs Assessment instrument should be replaced with a standardized Needs Assessment instrument.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Dr. James Austin or Private Contractor | Standardized instrument | JABG |

2. Secondary assessments using standardized instruments are recommended on those domains identified at intake as requiring further evaluation.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| YSA, CBOs | Secondary Assessment Instrument | CYSA, EPSDT |

3. Prior to discharge from Juvenile Hall, each minor should have a written Educational Plan that includes pre-vocational goals for the older minor, a Health Care Plan that includes a Mental Health Treatment Plan and a Substance Abuse Treatment Plan that guides the next stage of intervention upon release.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| ACOE, BHCS, Probation | Education Plan / Heath Plan | Blended funding |

4. A core substance abuse program should contain but not be limited to the following components: a more detailed intake screening instrument; secondary assessments where indicated by the intake screening, a written intervention plan, a written reentry plan, substance abuse education, substance abuse pre-treatment groups to prepare youth for treatment upon release and individual sessions as needed.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Thunder Road | Substance Abuse screening and treatment plan; pretreatment groups | Grants |

5. A core mental health services program should include but not be limited to the following components: a more detailed intake screening instrument approved by the Center for Behavioral Health Care Services and the Juvenile Hall intake staff, a secondary assessment for more youth where indicated by the intake screening, a written intervention plan, a written reentry plan, cognitive behavioral groups and individual sessions as needed.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation BHCS | Screening, treatment plan | EPSDT, Prop 36 |

6. A core program of cognitive behavioral change group sessions should be developed for and provided to all minors detained giving higher priority to changing minors' criminal attitudes, thinking patterns and behaviors.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Core programs of CBT groups; Probation ACOE, BHCS | CBT Group sessions | Blended funding |

## 1.4 JUVENILE HALL (CONTINUED)

7. One staff member should be designated to recruit mentors, student interns and Foster Grandparents to provide services to more housing units. Local businesses should be recruited to give presentations to minors at the JH and Camp Sweeney to expose minors to multi-cultural employers who operate successful businesses.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Recruitment and training of Juvenile Hall volunteers, interns, groups, mentors | General Fund/Grant |

8. Juvenile Counselors should be trained to co-facilitate with outside contractors or facilitate cognitive behavioral change groups

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Staff training counseling | General Fund |

9. TANF funding should be explored for the Juvenile Hall to conduct mental health assessments, mental health treatment, substance abuse assessments, education and pre-treatment groups, and cognitive behavioral change programs to youth confined in the Juvenile Hall.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Assessment instruments; training programs | James King Fund |

10. Prior to discharge, every child should have a Reentry Plan and staff should be given appropriate time to prepare the Reentry portfolio so that every child who is discharged has a plan. The Probation Department and the Juvenile Court should work together on developing a coordinated reentry protocol.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, ACOE, BHCS | Discharge reentry plan | Blended funding |

11. An automated information system should be created so that Juvenile Hall staff, teachers, health and mental health staff can transfer needed information electronically about the child in detention.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, ACOE, BHCS | Shared information system | Blended funding |

## 1.4.1 JUVENILE HALL EDUCATION

1. Prior to discharge, a post-test should be conducted on all minors to measure gains in academic achievement while at the Juvenile Hall.
2. The career interests and employability of older minors who are likely to enter the workplace upon release should be evaluated while in detention.
3. Prior to discharge, each minor should have a written Educational Plan with specific reentry educational and employment goals
4. Students should be exposed to the work-place literacy skills curriculum identified in the Secretary's Commission of Achieving Necessary Skills (SCANS)[2]
5. A job readiness skills training program should be provide for older minors to expose them to various trades and careers, to generate interest in the workplace, o prepare oneself for a job, to write winning resumes, and more importantly, to acquire the social, communication and emotional skills to retain a job.
6. A program of GED preparation and testing should be provided at the Juvenile Hall.
7. A formal ESL program should be established to educate the non-English speaking student.
8. An after-school program that includes homework and tutoring should be established in the daily curriculum and Juvenile Counselors and volunteers should assist youth with their homework.
9. A School Based Health Center (SBHC) for minors confined in the Juvenile Hall and Camp Sweeney is recommended.
10. The Local Service Area Programs located in schools and these School Based Health Centers should examine the services provided by each of these programs in these schools and develop a coordinated plan to ensure that these two programs complement one another rather than duplicate services.

| SERVICE PROVIDERS | SERVICE PROVIDED |
|---|---|
| ACOE/Probation | All recommendations concerning the educational assessment, instructional programming and tracking of detainees in the county juvenile institutions are primary responsibilities of the Alameda County Office of Education in partnership with probation. |

[2] What Work Requires of Schools: A SCANS Report for America 2000, from the Secretary's Commission on Achieving Necessary Skills (SCANS). U.S. Department of Labor, June 1991.

## 1.5 CAMP WILMONT SWEENEY

1. The Camp's mission, overall goals and program should be modified to provide the Juvenile Court an intermediate sanction for probation violators, for minors not suitable for group home placement and for minors who do not need to be committed to the California Youth Authority. The length of time spent at the Camp is recommended to be "competency-driven" based on youth's achieving specific program goals.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Contractors | Competency-driven program, Pre & Post assessment | General fund |

2. The specific type of program for each youth should be based on the assessment of risk and needs and the development of a case plan.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Contractors, Volunteers, BHCS, ACOE | Needs-based program | General fund/TANF |

3. Develop a formal Reentry Aftercare program for minors discharged from the Camp.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Contractors, | Relapse groups, Independent living skills, Mentors | General fund, TANF |

4. Performance measures should be developed to evaluate the successful completion of programs while at the Camp, the achievement of treatment goals and the number of major and minor incidents at the Camp. An automated database should be implemented to track the performance of program goals and the minor should be tracked 6, 12 and 18 months following discharge from the Camp to measure rearrests and readjudications.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Performance measures for program evaluation | General fund, TANF |

5. Residential treatment within the County for girls should be developed within the County either through contracts with treatment providers or by designating a portion of the Camp.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Girls' residential treat program | General fund, Title IV-E |

6. The Workforce Investment Act should be explored to fund vocational training, job readiness and job retention training. TANF and EPSDT should be explored to fund assessments and expanded counseling and MOU should be discussed with Alameda County Office of Education to provide psycho-educational groups at the Camp.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Contractors | **Vocational training; Job readiness training** | TANF, EPSDT |

## 1.5.1 CAMP SILMONT SWEENEY EDUCATIONAL PROGRAM

1. Every child who arrives at the Camp should have an educational assessment and an Educational Plan with specific educational goals developed while they were at the Juvenile Hall.
2. The career interests and employability of older minors who are likely to enter the workplace upon release should be evaluated while at the Camp using standardized assessment instruments.
3. A job readiness skills training program should be provided for older minors to expose them to various trades and careers, to generate interest in the workplace, to teach them the skills to locate employment, to prepare oneself for a job, to write winning resumes, and more importantly, to acquire the social, communication and emotional skills to retain a job.
4. The Camp administration and educational staff should ensure that the teachers have input into the Reentry Plan for each Camp student.
5. An automated information system should be created so that Camp staff, teachers, health and mental health staff can share needed information electronically about the child in the Camp.

| SERVICE PROVIDERS | SERVICE PROVIDED |
|---|---|
| ACOE/Probation | All recommendations concerning the educational assessment, instructional programming and tracking of detainees in the county juvenile institutions are primary responsibilities of the Alameda County Office of Education in partnership with probation. |

## 1.6 ALTERNATIVES TO PLACEMENT

1. The Family Preservation Unit should be reexamined to increase its effectiveness.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation - Family Preservation | Enhance and update program services by clarifying goals and performance measures to evaluate its success. | Title IV-E; General Fund |

2. Youth should be placed into FPU if the risk and needs assessment indicates that they require this high level of supervision and monitoring.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation - Family Preservation | Secondary assessments of youth and family | Federal: Safe Families Act |

3. Families involved in FPU should be offered family counseling and parenting skills training. The Probation Department and the Social Services Agency should reallocate some of the out-of-home placement funds currently being used for youth in placement to fund the Family Preservation Unit, FFT and the Multi-Systemic Therapy for serious offenders on probation.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation - Family Preservation | Service Referrals for: academic tutoring and monitoring, counseling and treatment health care education and referral, financial planning strategies, job preparation and employment recreational activities. Wrap-around service funds | Federal: Safe Families Act |

4. An automated database should be created that monitors the outcomes of the cases on Family Preservation, tracks the youth discharged from FPU 6 and 12 months following discharge and provides monthly and quarterly reports on the outcome of the program.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Court | Probation has initiated RFP for automated information system. | General Fund |

5. Pathways to Change should be fully maximized by the Probation Department.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| CBOs, Safe Passages | • High-level supervision and monitoring of youth<br>• Re-entry and after-care services | Federal Title IV-E and General Fund, Title V, Measure Y |

## 1.7 REENTRY AND AFTERCARE SERVICES

1. Alameda County should consider establishing a Reentry Court for youth coming out of CYA facilities to ensure that these youth comply with conditions and receive aftercare support to reduce their future rearrests and readjudications.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, BHCS, SSA, ACOE and CYA | • Multi-systemic assessment team<br>• Re-entry unit to serve youth released from Placement, Camp Sweeney and Juvenile Hall<br>• Collaboration with CYA to provide supervision of parolees to reduce duplication of services and provide local control | Prop 63 State Funding, General Fund |

2. It is recommended that the Probation Department establish a Reentry Unit that would serve youth released from
   - Placement
   - Camp Sweeney
   - Juvenile Hall
   - A Reentry Plan should be developed by the Reenry Unit prior to a minor being released from any facility.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Establish a Reentry Plan and Field Unit Program for youth who are released from Placement (foster, group home), Camp Sweeney, or Juvenile Hall, utilizing community service providers and Mentors. The formalized aftercare program may reduce costs for and time spent in placement and expedite family reunification. | OJJDP and General Fund |

3. Thunder Road is an excellent resource to the Probation Department and one in which is being underutilized. Thunder Road's group home could serve as a transitional facility for youth coming out of Camp Sweeney and Intensive Outpatient services could serve as aftercare for youth who do not require housing.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Court, PD and DA | Juvenile Drug Court | EPSDT, Prop 63 |

4. The Probation Department should work together with the local CYA Parole office to reduce redundancies of supervision of those minors who are also under supervision by CYA Parole.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, Courts, DA, PD, BOC | CPOC is currently in dialogue with YACA to explore the feasibility of local probation department assuming CYA parole responsibilities. | CYA and General Fund |

## 1.7 (continued)

5. Alameda County should expand its use of the Independent Living Skills Program for youth aging out of probation to provide needed life skills, employment, housing, health care and other transitional services to help prepare them for self-sufficient adulthood.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation, BHCS, SSA, ACOE and CYA | Transitional services for youth released from Placements including independent living, employment and secondary education support | Prop 63 State Funding, General Fund |

6. Alameda County should also explore Transitional Living Apartments for older youth released from Camp Sweeney, Juvenile Hall and placement facilities.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| SSA, ILSP | Transitional Housing | |

7. The Probation Department should contact Representatives in Congress to indicate their support for the Responsible Reintegration of Youthful Offenders/ Reintegration of Youthful Offenders Program (S.2810).

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| Probation | Reintegration program support | N/A |

## 1.8 OTHER RECOMMENDATIONS

1. The project team recommends that an on-going mechanism be authorized to continue the discussions on juvenile justice reform and to develop Action Plans to implement some of the recommendations found within this report.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| ICPC, Public Protection | Juvenile Justice Reform | Grants; Blended funding |

2. After the final Report and its recommendations are approved by the Alameda County Board of County Supervisors, a Staff and Community Education Plan should be developed and implemented to train staff and to inform community members of the recommendations.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| BOS, Probation | Staff and Community Education Plan | Grants |

3. It is recommended that key community leaders be invited to participate in further discussions on juvenile justice reform and to solicit their support in developing and implementing specific Action Plans in their communities.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| BOS, Probation | Community Support | Grants |

4. To initiate contracts/Memorandum of Agreements with existing public and private agencies and to develop grants with funding agencies, the project team recommends the designation of an Administrative /Grants liaison in Alameda County.

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| ICPC | Grant Development/designation of grants liaison | Grants |

5. Alameda County should further develop and implement a Youth Development Strategy that enhances the safety of communities so youth can grow and thrive, that promotes a community culture that values and supports youth, that strengthens their communities, that “provides them opportunities to contribute to their community, gain leadership skills, and ensures that youth have the opportunities to acquire and strengthen their sense of competence, usefulness, belonging and power—the four key principles of youth development..

| SERVICE PROVIDERS | SERVICE PROVIDED | FUNDING SOURCE |
|---|---|---|
| ICPC | Youth Development Strategy | Grants |

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) SafePassages

Contact Person: Quinta Seward, Ph.D.

Address: 250 Frank Ogawa Plaza, Ste. 6306; Oakland, CA 94612

Phone No./ Email address: 510-238-4456 qseward@oaklandnet.com

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

X Children & Youth (0-18) X Transition Age Youth (14-25) X Adults (18-59) ❒ Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
X At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
X Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

**Safe Passages MHSA Continuity of Care Funding Recommendations- Executive Summary**

## Organizational Background

Safe Passages is an inter-governmental partnership including the City of Oakland, the County of Alameda, the Oakland Unified School District (OUSD), San Lorenzo Unified (SLZUSD), philanthropy and community-based partners that is committed to advocating for children, youth, and families with a **special emphasis on vulnerable populations within the County of Alameda.**

## Data Sources

Data for this report was gathered from several sources including: published academic research; Federal, State and local governmental reports (such as the Census, Oakland Police Data and Alameda County demographic data); internal Safe Passages best practices research & evaluation outcomes; nationally-recognized policy organizations and foundations; anecdotal information and industry-standard observations.

## Recommendations

In keeping with the Prevention and Early Intervention (PEI) Funding Criteria of the Mental Health Services Act (MHSA), Safe Passages strongly encourages decision makers to support a continuum of care approach to address the needs of young children, adolescents and young adults, from birth to 25, at critical stages in their development with a specific emphasis on serving populations living in high concentrations of poverty and domestic and community violence. Along this continuum of care, Safe Passages strongly recommends that a portion of PEI funding be directed at serving high need populations that are not eligible to receive full scope Medi-Cal, are uninsured or lack viable alternatives to health care and mental health services, and those who cannot access services due to the lack of culturally and linguistically appropriate services. These populations represent Alameda County's most underserved residents.

### Mental Health Need: Disparities in Access to Mental Health Services for At-Risk Children, Youth and Young Adult Populations

Key factors that inhibit the most vulnerable populations in Alameda County from receiving needed health and mental health services include: a rapidly growing immigrant population that are ineligible for full-scope Medi-Cal; living in high levels of poverty and violence; limited access to health care; limited knowledge of services; and language & cultural barriers. Children who grow up in poverty are more likely to live in a more stressful environment, have less access to nutritional diets, and fewer community resources, including schools. According to 2000 US Census data, the percentage of children in Alameda County under the age of 18 living below the poverty level was 17 percent.[i]

Many communities within Alameda County are located in neighborhoods with high concentrations of poverty and are also experiencing major demographic shifts. For example, in the unincorporated areas of Ashland / Cherryland, the following demographic shifts occurred between 1990 and 2000:

- The White population experienced a decrease of 33% to a population of 10,629.
- The Asian and Pacific Islander population increased 96%, reaching 4,336.
- The Latino population grew by 90% to 12,060.
- The African American population nearly doubled to 5,385.[ii]

Further, many neighborhoods in Oakland are experiencing similar demographic shifts over the same time period. Schools in East Oakland have shown an increase in the Latino population, which housed predominantly African-American students in the late 1990's and currently host populations that are 50% or more Latino children and families.[iii] Often these families represent immigrant groups from Mexico and Central America. In other areas of Oakland, schools are experiencing an increase in Asian populations, from Cambodia, Vietnam and Laos. These families are often not eligible to receive full scope Medi-Cal and other public-assistance benefits, nor are there dedicated funding streams to serve these populations.

*Limited Access to Health and Mental Health Care for Uninsured Families*

In 2001, the Alameda County Board of Supervisors published a report that stated that "approximately 81,000 to 90,000 Alameda County children and parents are uninsured." In addition, approximately 13 to 15 percent of uninsured children and families are ineligible for any public health insurance programs. However, over 68% of uninsured families are eligible but not enrolled in Medi-Cal or Healthy Families. The study also found that more than 70% of the County's uninsured are people of color and more than 50% of the uninsured are immigrants.[iv] Further, a recent report published by the Kaiser Family Foundation found that "the relationship between ethnicity and health access is documented" and ethnic and racial groups continue to "bear a disproportionate burden of mortality and morbidity across a wide range of health conditions.[v]

*Cultural Competence and Culturally Appropriate Services*
Compounding the challenge further, racial and ethnic minorities are seriously unrepresented in the core mental health professions – thus, "culturally competent" care is scant. In general, the culture and language of clinicians and the larger health care system govern the societal response to a patient with mental illness. Cultural values dictate the delivery of care, diagnoses, treatments and the reimbursement of services. Clinicians and systems in the US have been ill-equipped to meet the needs of patients from different backgrounds and often display bias in the delivery of care.

**Priority Populations: Underserved Cultural Populations, Children & Youth in Stressed Families, Children & Youth at Risk for School Failure and Children & Youth at Risk of Juvenile Justice Involvement.**

Early Childhood - Children Birth to Five
Exposure to violence in infancy and early childhood has far-reaching developmental, behavioral and emotional consequences. Research suggests that children are at greatest risk for adopting aggressive behavior when exposed to extreme violence before the age of five, and that 50% of children exposed to trauma before the age of ten develop psychiatric problems later in life.[vi]

*Best Practice Principles*
Best practices in early childhood prevention and intervention stress that early intervention is key and tend to have common underlying principles, including: assessment and treatment of maternal depression; focus on root causes of behavioral and emotional problems; developmentally appropriate activities; involvement of the child, primary caregiver, and/or child care provider; intensive services targeted at high-risk children and families; utilization of a strengths-based approach; and production of short- and long-term outcomes.

*Models*
Models currently implemented in Alameda County through City of Oakland Measure Y funds, and the Oakland Unified School District include: Second Step Violence Prevention curriculum, where young children learn the importance of peaceful problem-solving and how to articulate emotions; mental health consultation, where clinicians observe the interaction between teachers & staff with young children in the pre-school setting; police trainings in which a collaborative of Safe Passages, the Alameda County District Attorney's Office and Public Health Department, along with clinicians, Early Childhood experts from local CBOs and the Oakland Police Department provide County-wide trainings for police officers on the impact of community and domestic violence on infants/babies (0-5).

Adolescent School-Linked Services
Researchers assert that the developmental processes that all adolescents experience as they mature into adulthood put them at risk for violence [vii] School-based services that are intensive and seek to prevent further levels of care and which address the needs of families with a comprehensive array of professional services are the most successful in reducing risk factors for adolescents.

*Models*
In Alameda County, Safe Passages and the Alameda County Our Kids program in partnership with local school districts and community based organizations work together to implement a multi-pronged approach to serve middle school populations in the County. In OUSD, Safe Passages and Our Kids serves 14 middle schools. In San Lorenzo Unified School District, the partnership serves 2 schools, and in Hayward Unified the Our Kids program serves 11 schools; however, the need is much greater than the amount of families and children currently being served. Mental health services are funded through EPSDT funding. Similar to the gap population described in the Early Childhood section, at risk youth and their families that are not eligible to receive Medi-Cal often go without receiving these needed services.

Youth involved in the Juvenile Justice System
Risk factors for school failure, and for serious and violent offenses that may lead to future involvement in the juvenile justice system include: academic difficulties due to unidentified learning disabilities or mental health issues; stressful peer relationships and association with violent and delinquent peers; aggressive behaviors; lack of support at home; gang involvement; lack of experienced teachers, guidance counselors & extracurricular activities; unsafe, ill-equipped educational facilities; lack of sufficient resources for schools and increasingly harsh disciplinary practices such as suspensions and expulsions.

*Best Practice Principles*
According to research and evaluation of best practices in violence prevention programs for youth offenders, effective programs are those that incorporate the following principles strengths-based approaches: strategies that empower families to support youth's positive activities, graduated sanctions and services that link youth to highly structured program activities in the communities in which they live.[viii]

**Young Adults**
Prevention and intervention programs for young adults are essential for providing social and mental heath services along the continuum. Prevention programs, such as Peer Conflict Mediation and Violence Prevention Curriculum, help young people learn to handle conflicts in a pro-social manner and reduce impulses that lead to criminal behavior. Intervention programs work with youth and young adults who are the most likely to be involved in crime, and provide them with the guidance they need to lead productive, non-criminal lifestyles. Employment and Training programs offer young adults positive alternatives to unproductive behavior and develop young people's view of themselves as adults contributing to the health of their community. Assessment and treatment of maternal depression include regular screenings by child's physician concerning mother-child interactions as well as therapy and/or use of anti-depressants.

*Models*
Pathways to Change in Oakland, is a diversion program for repeat juvenile offenders on probation. It is the first diversion program in Alameda County, and was developed by Safe Passages in partnership with Alameda County Probation Department, the City of Oakland, and several community-based organizations. The program pairs youth offenders with case managers who serve as mentors and role models while providing on-going supervision through the court process. This program to date has produced a 50% reduction in re-offenses and improved school attendance rates among participants.

Project First, also developed by Safe Passages with the Oakland Police Department, combines several program components derived from national model programs cited by the Office of Juvenile Justice, including the Repeat Offender Prevention Program. Project First offers assessment, case management and intervention services to first time offenders on Court Ordered Informal Probation and their families. A multi-disciplinary team provides intervention services that include mentoring, counseling, educational/vocational services and after-school enrichment activities. Parent counseling and education and support groups are also provided.

Although the City of Oakland supports these programs there is a need to expand and develop additional programs and services to other high need areas of the County.

**Conclusion:**
Safe Passages believes that mental health must be broadly interpreted and should include a spectrum of prevention and intervention programs utilizing a continuum of care approach from early intervention of young children, to adolescents and young adults that targets the most vulnerable populations, particularly those in which there are no dedicated funding streams. Striking disparities in mental health services exist among racial and ethnic minority populations, as these populations are more likelihood of living in poverty, less likely to have access to services; less likely to receive needed mental health care; often receive poorer quality care; and are significantly underrepresented in mental health research.[ix] Additional barriers for these populations include: mistrust and fear of treatment; preconceived cultural ideas about illness and health; difference in help-seeking behaviors, language, and communication patterns; lack of insurance; and racism and discrimination by individuals and institutions (which also contribute to lower economic, social and political status).

Further, Safe Passages advocates for the use of PEI funding to:

- Support the recommendations of the Alameda County Early Childhood Mental Health Planning Committee;
- Expand effective programs that serve early childhood, adolescent, children at risk for juvenile justice involvement and young adult populations in other high need areas of Alameda County;
- Provide culturally and linguistically appropriate services to other high risk populations that are currently not funded through Medi-Cal or other existing funding streams.

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[i] US Census Bureau website, www.census.gov
[ii] Community Assessment, Planning and Education Unit. Public Health Department, Alameda County Health Care Services Agency. *.Ashland / Cherryland Community Information Book, 2001.*
[iii] Oakland Unified School District Research Assessment and Accountability Department (2007-2008).
[iv] Alameda County Children and Families Health Insurance Task Force. *A First Step Towards Comprehensive Health Coverage* (2001).
[v] Kaiser Family Foundation and the UCLA Center for Health Policy Research. *Racial and Ethnic Disparities in Access to Health Insurance and Health Care.*
[vi] J. Davidson and R. Smith, "Traumatic Experiences in Psychiatric Outpatients." Journal of Traumatic Stress 3 (1990): 459-475.
[vii] Deborah Prothrow-Stith and Howard R. Spivak, *Murder is No Accident* (San Francisco : Jossey-Bass, 2004), 168.
[viii] Beyer, Marty. "Best Practices in Juvenile Accountability," OJJDP Juvenile Accountability Block Grant Series Bulletin, U.S. Department of Justice (April 2003), http://www.ncjrs.org/html/ojjdp/184745/contents.html (accessed May 2004).
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# Safe Passages MHSA Continuum of Care Policy Recommendations

## OVERVIEW

Safe Passages is an inter-governmental partnership including the City of Oakland, the County of Alameda, the Oakland Unified School District (OUSD) and San Lorenzo Unified School District (SLZUSD), philanthropy and community-based partners that is committed to advocating for children, youth, and families with a special emphasis on vulnerable populations within the County of Alameda.

In keeping with the Prevention and Early Intervention (PEI) Funding Criteria of the Mental Health Services Act (MHSA), Safe Passages strongly encourages decision makers to support a continuum of care approach to address the needs of young children, adolescents and young adults, from birth to 25, at critical stages in their development with a specific emphasis on serving populations living in high concentrations of poverty and domestic and community violence. Along this continuum of care, Safe Passages strongly recommends that a portion of PEI funding be directed to serving high need populations that are non Medi-Cal eligible, are uninsured and who lack other viable alternatives to health care and mental health services. These populations represent Alameda County's most underserved, who often lack access to health and mental health services. Finally, Safe Passages encourages decision makers to support and fund culturally and linguistically appropriate services.

## INTRODUCTION

This paper will provide a brief description of the demographic shifts in Alameda County, a description of best practices along the proposed continuum of care approach, and recommendations for use of PEI funding.

### *Demographic shifts in Alameda County*

Key factors that inhibit the most vulnerable populations in Alameda County from receiving needed health and mental health services include: living in communities with high concentrations of poverty and violence; rapidly growing immigrant populations that are ineligible for full scope Medi-Cal; limited access to health care, as well as limited knowledge of services; and language and cultural barriers.

Alameda County, comprised of fourteen cities and several unincorporated areas, is the fifth largest county in the state. The county covers 813 square miles and has a population of 1.4 million residents. The communities in the County are highly varied by race, ethnicity, income levels and topography. The racial and ethnic composition for the County of Alameda, as reported by residents during the 2000 US Census, is as follows: 48.8% Caucasian, 20.4% Asian, 19% Hispanic or Latino, 14.9% African American, 8.9% some other race, 5.6% two or more races, 0.6% Native American and Alaska native, and 0.6% Native Hawaiian and other Pacific Islander. Children under 4 years of age comprise 6.8% of the population in Alameda County, children 5 - 9 comprise 7.2%, children 10 – 14 comprise 6.7%, and children 15 – 19 comprise 6.4% of the population.[i] A report written by the California Food Policy Advocates reports that Alameda County ranks 46th out of 58 counties in California in poverty, and 45th in child poverty.[ii]

According to a 2004 US Census report, more Americans fell into poverty in 2004. The rate of poverty in Alameda County rose from 10.8% in 2000 to 11.4% in 2004. Though the federal poverty level varies by household size, in 2004 it was $18,850 for a family of four.[iii] The California Budget Project has established that a two child, single parent family in Alameda County would need an annual income of $61,984 to adequately raise a family.[iv]

Children who grow up in poverty are more likely to live in stressful environments with high rates of domestic and community violence, have less access to nutritional diets, and fewer community resources, including businesses, banks and grocery stores.[v] According to 2000 US Census data, the percentage of children in Alameda County under the age of 18 living below the poverty level was 17 percent.[vi]

### *Growing Ethnic and Cultural Populations living in High Concentrations of Poverty*

Many high need communities within Alameda County are also experiencing major demographic shifts. In the East Oakland neighborhood of Sobrante Park, significant demographic changes have occurred over the last ten years, with a large increase in immigrant populations. This area of Oakland has some of the highest crime rates in the city and the greatest number of community stressors.[vii] These stressors include high juvenile arrest rates, high levels of domestic violence, child abuse reports and unemployment.

Schools in the Sobrante Park area have Free and Reduced Lunch rates of at least 80%. These schools were predominantly African-American in the late 1990's and now host populations that are 50% or more Latino children and families.[viii] Often these families represent immigrant groups from Mexico and Central America. In other areas of Oakland, with large Asian populations, schools are experiencing increases in Cambodian, Vietnamese and Laotian populations.[ix] These families are often not eligible to receive full scope Medi-Cal and other public-assistance benefits, nor are there dedicated funding streams to serve these populations.

Beyond Oakland, the unincorporated areas of Ashland/Cherryland of the County have a similar set of conditions. These unincorporated areas have a high number of community stressors and high levels of poverty; and have experienced major demographic shifts. According to the Ashland/Cherryland Community Information Book, 2001, prepared by Alameda County Public Health, about 40% of households earned an income of $30,000 in 1999, as compared to 28% in Alameda County as a whole. As of December 1999, about 10.6 out of 1,000 children were confirmed as abused or neglected, compared with the County rate of about 6 per 1,000. Data provided by the Alameda County's Sheriff's office, show that juvenile arrests in the Ashland/Cherryland areas have more than doubled over the last four years, rising 127% between 2002 and 2005 from 74 to 168 arrests.[x] The following demographic shifts occurred:

- The White population experienced a decrease of 33% between 1990 and 2000, to a population of 10,629.
- The Asian and Pacific Islander population increased between 1990 and 2000 of 96%, reaching 4,336.
- The Latino population grew by 90% to 12,060.
- The African American population nearly doubled, from 1990 to 2000 to 5,385.[xi]

*Uninsured Families*
In 2001, the Alameda County Board of Supervisors published a report that stated that "approximately 81,000 to 90,000 Alameda County children and parents are uninsured." In addition, approximately 13 to 15 percent of uninsured children and families are ineligible for any public health insurance programs. However, over 68% of uninsured families are eligible but not enrolled in Medi-Cal or Healthy Families. The study also found that more than 70% of the County's uninsured are people of color and more than 50% of the uninsured are immigrants.[xii] Further, a recent report published by the Kaiser Family Foundation found that "the relationship between ethnicity and health access is documented" and ethnic and racial groups continue to "bear a disproportionate burden of mortality and morbidity across a wide range of health conditions."[xiii]

*Continuum of Care Services Approach*
A continuum of both health and mental health services that begins at birth and extends through early adulthood is needed to best reach young children, adolescents and young adults at critical stages in their development. Research indicates that intervening early in the lives of children exposed to trauma can help prevent the onset of mental health issues later in life.[xiv] The next critical stage of child development is adolescence, when children experience vulnerabilities that put them at high-risk for a variety of behaviors including violence[xv] involvement in the juvenile justice system, substance abuse, and school failure. Providing prevention and intervention programs and services that meet the needs of these youth helps improve their chances of making healthy decisions into adulthood. When youth become involved in the juvenile justice system, additional supports are needed to prevent them from declining further into this system. As youth develop into young adulthood additional programs and services are needed to assist them with employment and educational options. The following sections provide research and best practices along the continuum of care approach.

<u>Early Childhood - Children Birth to Five</u>
Exposure to violence in infancy and early childhood has far-reaching developmental, behavioral and emotional consequences. Research suggests that children are at greatest risk for adopting aggressive behavior when exposed to extreme violence before the age of five, and that 50% of children exposed to trauma before the age of ten develop psychiatric problems later in life.[xvi] Increasingly, research shows that trauma, stress, violence and fear can permanently alter the brain chemistry of infants and young children, possibly leading to a lifetime of social-emotional and/or behavioral disorders. Children exposed to community and domestic violence must learn and grow despite an ever-present feeling of threat and danger. Persistent fear and the neuro-physiological adaptations to this fear can alter the development of the child's brain, resulting in changes in emotional, behavioral, cognitive and social functioning.

Infants and young children have limited tools with which to respond to fear, and, when they are not effectively soothed, can develop a host of stress reactivity responses, such as: "learned helplessness," a defeat reaction common in abused or neglected children; dissociation, a broad term that includes a variety of mental mechanisms which allow children to disengage from the external world; and a host of hyper-arousal related symptoms and disorders, such as Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, etc. Children exposed to traumatic events, including exposure to violence or routine verbal assault, either as witnesses or direct victims, exhibit a wide range of symptoms, presenting with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and defiant behavior. The poor behavior exhibited by young children who have been exposed to violence or other traumatic events leads to a variety of consequences that are costly to individual families and society, including:

- Poor attention and learning challenges in school and lower grades
- Pre-school expulsions - For every 133 pre kindergarten students in California, one is expelled. This is 3X the rate of expulsion in California k-12 schools.[xvii]
- Future truancy, suspensions and expulsion and possible involvement in the juvenile justice system
- Increased parental stress and inability to cope with life challenges

Fortunately, this period of vulnerability in early childhood also represents a window of opportunity for effective interventions with children and their primary caregivers. Studies show that the younger the child, the greater the likelihood that a parent intervention will be successful, since behavior patterns in both the parent and child have not yet become entrenched.[xviii] Early childhood interventions have been shown to be cost-effective and produce long-term results.[xix]

*Early intervention*
Early intervention has proven a much more cost effective option to the community at large. Inversely, without early intervention programs, children fall through the cracks and may enter a more costly foster care, special education, and/or juvenile system when older.
Consider the financial costs to residents of Alameda County when a young child is underserved. The cost of foster care placement per child annually is up to $144,000.[xx]

Children who are exposed to trauma are likely to experience learning difficulties which often lead them into a costly special education system -- spending anywhere between 1.5 to 4 times more on these children than on children not needing special education services. Finally, and more alarmingly, it costs approximately $175,000 per year for a juvenile placed in the custody of the state's Division of Juvenile Justice (CJJ, formerly known as the California Youth Authority). Further, consider that the average stay in CJJ is 21.9 months with a total price tag per ward of $319,375.[xxi] In addition, repeat crimes lead to massive costs in enforcement, loss of property, and loss of life.

*Best Practice Principles and Models*
Best practices in early childhood prevention and intervention stress that early intervention is key and tend to have common underlying principles, including:

Focus on root causes of behavioral and emotional problems

- Developmentally appropriate activities
- Involve child, primary caregiver, and/or child care provider
- Intensive services targeted at high-risk children and families
- Employ a strengths-based approach
- Produce short- and long-term outcomes

Alameda County has strong existing collaborations that focus on the needs of children birth to five and that promote these principles. This includes Safe Passages, First 5 Alameda County, the City of Oakland's Department of Human Services, Alameda County Behavioral Health Services Agency and a mental health collaborative, which consists of community based organizations that serve this population. These groups work together to provide a range of services to meet the needs of children birth to five. Services include mental health consultation; case management; and other more intense interventions such as Parent/Infant Psychotherapy to young children and their families in need and often rely on the Early Periodic Screening Diagnostic Treatment (EPSDT) funding to provide this work. However, many families, especially due to the increase in immigrant populations and the ever changing circumstances of the poor, are not eligible for full

scope Medi-Cal and other public benefit programs. Unfortunately there are no dedicated funding streams to serve these families. This is a significant gap in Alameda County's ability to serve underserved populations.

Safe Passages supports the recommendations in the report submitted by the Alameda County Early Childhood Mental Health Planning Committee, which states that there should be funding through the MHSA PEI to provide preventative services to our youngest children, based on the most effective ways to do so and the strengths and gaps in care for young children in Alameda County. Those recommendations address the local community mental health needs of at-risk children, and also address the needs in "Disparities in Access to Mental Health Services."

Adolescent School-Linked Services

The next critical developmental stage is adolescence. As mentioned previously, adolescent youth, experience vulnerabilities that put them at high-risk for a variety of behaviors including involvement in the juvenile justice system, substance abuse, violence and school failure. These risk factors may lead to academic difficulties, stressful peer relationships, associations with violent and delinquent peers, aggressive behaviors and future involvement in the juvenile justice system. Research shows that school-based services are the most effective in reaching this population.

*Best Practice Guidelines*

The School Mental Health Program established in 1989 to advance school-based services provides the following guidelines to improve the school environment and promote mental health for all students:

- Address and modify risk and protective factors that indicate possible mental health concerns
- Intervene in multiple settings, with a focus on schools
- Focus on skill building, empowerment, self-efficacy and individual resilience, and respect
- Train non-professionals to establish caring and trusting relationships
- Involve multiple stakeholders
- Provide comprehensive support systems that focus on peer and parent-child relations, and academic performance
- Adopt multiple interventions
- Address opportunities for organizational change, policy development and advocacy
- Demonstrate a long-term commitment to program planning, development and evaluation
- Ensure that information and services provided are culturally appropriate, equitable and holistic[xxii]

*Comprehensive Mental Health Services*

Therapeutic services for adolescents have been one of the most underdeveloped sectors of mental health programming, research and policy. Services are generally restrictive or not intensive enough, culturally irrelevant, and short lived. Wrap-around services are intensive, community-based health services that seek to prevent further levels of care and which address the needs of families with a comprehensive array of home and/or school-based profession services, as well as personal support and community resources. By coordinating existing resources, it is possible to envelop the entire family and assist them with the challenges of raising children and adolescents.

School-based services that are intensive and seek to prevent further levels of care and which address the needs of families with a comprehensive array of professional services are the most successful in reducing risk factors for adolescents. These include implementing a multi-pronged approach, such as site-based case management and mental health, conflict resolution, family engagement and after school programs, and alternatives to suspension.[xxiii]

Safe Passages and the Alameda County Our Kids program in partnership with community based organizations work together to implement a multi-pronged approach to serve middle school populations in the County. In OUSD, Safe Passages and Our Kids serves 14 middle schools. In San Lorenzo Unified School District, the partnership serves 2 schools, and in Hayward Unified the Our Kids program serves 11 schools; however, the need is much greater than the amount of families and children currently being served. Mental health services are funded through EPSDT funding. Similar to the gap population described in the Early Childhood, birth to five section, at risk youth and their families that are not eligible to receive Medi-Cal often go without receiving needed services.

Youth involved in the Juvenile Justice System

Helping first time youth offenders stay out of the juvenile justice system reduces considerable public cost. As noted previously, it costs approximately $175,000 per year for a juvenile placed in the custody of the state's Division of Juvenile Justice (CJJ, formerly known as the California Youth Authority). In addition, repeat crimes lead to massive costs in enforcement, loss of property, and loss of life.

Existing data on first time youth offenders in Alameda County presents compelling arguments for intervening quickly with these youth. An analysis of Alameda County Probation Department data reported that:

- Approximately 4 out of 10 first time offenders will commit another crime within a year of being released from Juvenile Hall or probation.
- First time youth offenders constitute 65% of the juvenile arrests in Alameda County.
- Recidivism rates for youth on court-ordered informal probation is over 45% and recidivism rates increase significantly for youth once in court ordered placement to over 70 percent.[xxiv]

*Best Practice Principles*

According to research and evaluation of best practices in violence prevention programs for youth offenders, effective programs are those that incorporate the following principles:

- Use a strengths-based rather than a deficit-based approach to help youth develop empathy, learn how to anticipate outcomes of their actions, see alternatives to negative behaviors, and recognize that they have choices;
- Use graduated sanctions, including restorative restitution and community service, while recognizing that punishment does not make a young person accountable;
- Empower families to support youth's positive activities and efforts to succeed in school;
- Link youth to highly structured program activities in the communities in which they live.[xxv]

In July 2003, the City of Oakland updated its Violence Prevention Plan, which compiled information on existing violence prevention programs and concluded that there were little to no resources for first time offenders. Since then, the City of Oakland has allocated funds from the Violence Prevention and Public Safety Act of 2004 (Measure Y) to support programs to serve this population. These programs include Pathways to Change, an intensive case management model and Project First for first time youth offenders.

Pathways to Change in Oakland, is a diversion program for repeat juvenile offenders on probation. It is the first diversion program in Alameda County, and was developed by Safe Passages in partnership with Alameda County Probation Department, the City of Oakland, and several community-based organizations. The program pairs youth offenders with case managers who serve as mentors and role models while providing on-going supervision through the court process. This program to date has produced a 50% reduction in re-offenses and improved school attendance rates among participants.

Project First, also developed by Safe Passages with the Oakland Police Department, combines several program components derived from national model programs cited by the Office of Juvenile Justice, including the Repeat Offender Prevention Program. Project First offers assessment, case management and intervention services to first time offenders on Court Ordered Informal Probation and their families. A multi-disciplinary team provides intervention services that include mentoring, counseling, educational/vocational services and after-school enrichment activities. Parent counseling and education and support groups are also provided.

Although the City of Oakland supports these programs there is a need to expand and develop additional programs and services to other high need areas of the County.

Young Adults

Prevention and intervention programs for young adults are essential for providing social and mental heath services along the continuum. Prevention programs, such as Peer Conflict Mediation and Violence Prevention Curriculum, help young people learn to handle conflicts in a pro-social manner and reduce impulses that lead to criminal behavior. Intervention programs, like Pathways to Change and Project Choice, work with youth and young adults who are the most likely to be involved in crime, and provide

them with the guidance they need to lead productive, non-criminal lifestyles. Young Adults need additional services that support their transition into independence including employment and training programs that offer positive alternatives to unproductive behavior and develop young people's view of themselves as adults contributing to the health of their community. Further pregnant and parenting young adults often suffer from issues of poverty and stressors that affect them and their children. Services must be available to these vulnerable populations to ensure healthy outcomes.

*Employment and Training for Parolees, Probationers, and High Risk Youth*
At high-risk youth face special barriers to employment and typically require support services such as counseling, as well as training education opportunities to facilitate their reintroduction into the community and improve their prospects for making contributions to society as productive citizens.

For high-risk adults, service strategies should focus on increasing these individuals' employment and earnings through work-based learning interventions such as on-the-job-training (OJT), apprenticeships, or job readiness training, along with occupational skills training and other necessary services based upon the development of an individual employment plan (which itself is an intensive service under the Workforce Investment Act). Providing "high risk" adults with training that is directly linked to local employment opportunities is important because it provides low-skilled individuals with a "real world" context for learning "real world" skills.[xxvi]

The City of Oakland provides the following services:

- *Intensive Reentry Training and Employment*, includes subsidized on-the-job training, helps to reduce the allure of the underground economy while skills are developed.
- *Crew-Based Shelter Employment* offers parolees subsidized work activity as part of an eight-person crew, such as Public Works, Fire Services, or Community Service.
- *Direct Placement* strategy prioritizes rapid attachment into employment via contracts that pay per client per job placement and retention benchmark.
- After-School Job Training helps high-risk youth acquire skills and contributes financially as well.
- Subsidized Summer Youth Employment provides job placements for high risk youth in Oakland's Mayor's Summer Jobs Program.[xxvii]

*Pregnant and Parenting Young Adult Women*
The consequences on the child of maternal depression are not restricted to "postpartum blues" but can extend through infancy, toddler-hood and school age. Depressed mothers generally show less attentiveness and responsiveness to their children's needs, are less likely to set limits and/or follow through, are more likely to have internalizing (depressed) and externalizing (aggressive, abusive) approaches to child rearing. Risk factors include marital conflict, high stress, poverty, lower social class and lower maternal education.[xxviii]

Infants, toddlers, and school-aged children of depressed parents, whose wide range of needs are most likely not being met, are at high risk for impaired adaptive functions, psychopathology, anxiety, illness, chronic stress problems, school failure and other social-emotional and behavioral problems. Recommendations from CPS in the treatment of maternal depression include regular screenings by child's physician concerning mother-child interactions as well as therapy and/or use of anti-depressants (during and after pregnancy). Additional research from Colombia University supported the use of anti-depressants for maternal depression in a study which found that, after 3 months of medication treatment, rates of maternal diagnoses of depression dropped 11%.

There is a scarcity of programs that address the needs of the young adult population in Alameda County including those at-risk for adult involvement in the criminal justice system; those reentering from incarceration; and programs and services for pregnant and parenting young women.

RECOMMENDATIONS
Safe Passages believes that mental health must be broadly interpreted and should include a spectrum of prevention and intervention programs utilizing a continuum of care approach from early intervention of young children, to adolescents and young adults that targets the most vulnerable populations, particularly those in which there are no dedicated funding streams. Striking disparities in mental health services exist

among racial and ethnic minority populations, as these populations are more likely to be living in poverty, less likely to have access to services; less likely to receive needed mental health care; often receive poorer quality care; and are significantly underrepresented in mental health research.[xxix] Additional barriers for these populations include: mistrust and fear of treatment; preconceived cultural ideas about illness and health; difference in help-seeking behaviors, language, and communication patterns; lack of insurance; and racism and discrimination by individuals and institutions (which also contribute to lower economic, social and political status).

Further, Safe Passages advocates for the use of PEI funding to:

- Support the recommendations of the Alameda County Early Childhood Mental Health Planning Committee;
- Expand effective programs that serve early childhood, adolescent, children at risk for juvenile justice involvement and young adult populations in other high need areas of Alameda County;
- Provide culturally and linguistically appropriate services to other high risk populations that are currently not funded through Medi-Cal or other existing funding streams.

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[i] US Census Bureau website, www.census.gov
[ii] California Food Policy Advocates. *Understanding and Improving the Food Stamp Program in California: A Primer and Policy Guide for Advocates.* (2001)
[iii] US Census Bureau website, www.census.gov
[iv] California Budget Project. *Locked Out: California's Affordable Housing Crisis* (May 2000).
[v] California Food Policy Advocates. *Understanding and Improving the Food Stamp Program in California: A Primer and Policy Guide for Advocates.* (2001).
[vi] US Census Bureau website, www.census.gov
[vii] City of Oakland Violence Prevention and Public Safety Act of 2004, Community Stressor Analysis Update 2006. In 2006, The City of Oakland and Safe Passages conducted a study of stressor indicator data to target funds to high need areas of the City. Community stressor data included arrests 18 and under, arrests 19-29, domestic violence, child abuse, violent crime, unemployment, poverty, chronic truants, violent suspensions within the police beats of each city council district.
[viii] Oakland Unified School District Research Assessment and Accountability Department (2007-2008).
[ix] IBID
[x] Alameda County Sheriff's Department Data, (2006).
[xi] Alameda County Health Care Services Agency, Public Health Department. *Community Assessment, Planning and Education Unit. Ashland / Cherryland Community Information Book, 2001.*
[xii] Alameda County Children and Families Health Insurance Task Force. *A First Step Towards Comprehensive Health Coverage* (2001).
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[xiv] J. Davidson and R. Smith, "Traumatic Experiences in Psychiatric Outpatients." Journal of Traumatic Stress 3 (1990): 459-475.
[xv] Deborah Prothrow-Stith and Howard R. Spivak, *Murder is No Accident* (San Francisco : Jossey-Bass, 2004), 168.
[xvi] J. Davidson and R. Smith, "Traumatic Experiences in Psychiatric Outpatients." Journal of Traumatic Stress 3 (1990): 459-475.
[xvii] Safe Passages. *Violence Prevention and Intervention Strategies: Outcome Evaluation Report.* (2004).
[xviii] Carolyn Webster-Stratton and Ada Spitzer, "Parenting a young child with conduct problems: new insights using qualitative methods," in Advances in Clinical Child Psychology, eds. Thomas H. Ollendick and Ronald J. Prinz (New York: Plenum Publishers, 1996), 1-62; Ted K. Taylor and Anthony Biglan, "Behavioral family interventions for improving childrearing: a review of the literature for clinicians and policymakers." Clinical Child and Family Psychology Review 1(1998): 41-60.
[xix] Greg Parks, "The High/Scope Perry Pre-School Project," OJJDP Juvenile Justice Bulletin, U.S. Department of Justice (October 2000), http://www.ncjrs.org/html/ojjdp/2000_10_1/contents.html (accessed June 8, 2004).
[xx] SSA/CWS, 9/5/2007, Basic rate for foster care placement for children 0-4 years of age: $425/month; Basic rate for foster care placement for children 5 years of age: $462/month. These rates do not include special care and attention increments, which can bring the monthly cost up to twice the basic rate. Also, these rates are what are paid to county licensed foster homes and relatives. If a child is placed in a Foster Family Agency (FFA), the basic rates are about $1,200/month and on up. Each FFA has its own approved rate.
[xxi] California Department of Corrections and Rehabilitation. (2007). Summary fact sheet. Retrieved on April 23, 2007 from http://www.cdcr.ca.gov/ReportsResearch/summarys.html
[xxii] Centre for Addiction and Mental Health. *School Mental Health Program Guidelines for Best Practices.*
[xxiii] Safe Passages. Best Practices- *A Snapshot of Proven Violence Prevention and Intervention Strategies (2004).*
[xxiv] Alameda County Probation Department Data.
[xxv] Marty Beyer, "Best Practices in Juvenile Accountability," OJJDP Juvenile Accountability Block Grant Series Bulletin, U.S. Department of Justice (April 2003), http://www.ncjrs.org/html/ojjdp/184745/contents.html (accessed May 2004).
[xxvi] US Department of Labor, www.doleta.gov, accessed on December 13, 2007.
[xxvii] City of Oakland Measure Y Initiative website www.measurey.org
[xxviii] Myra M Weissman and Daniel Pilarsky, *Treatment of Mothers Depression Reduces Risk of Disorders in Children*, published by Colombia University (2006).
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ALAMEDA COUNTY
Behavioral Health Care Services

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.


Organization* (if applicable) Seneca Center
Contact Person Ken Berrick
Address 2275 Arlington Drive
San Leandro, CA 94578
Phone No./ Email address 317-1446,ext. 222 ken@senecacenter.org


***Please attach a list of all groups and organizations that contributed to this report.***

***What age group does your organization serve or represent?***

☑ Children & Youth (0-18) ☑ Transition Age Youth (14-25) ☐ Adults (18-59) ☐ Older Adults (60+)

***Under each category, choose the item your report PRIMARILY addresses:***

Key Community Mental Health Needs

☐ Disparities in Access to Mental Health Services
☐ Psycho-Social Impact of Trauma
☑ At-Risk Children, Youth and Young Adult Populations
☐ Stigma and Discrimination
☑ Suicide Risk

Priority Populations

☑ Underserved Cultural Populations
☑ Individuals Experiencing Onset of Serious Psychiatric Illness
☑ Children/Youth in Stressed Families
☑ Trauma-Exposed
☐ Children/Youth at Risk for School Failure
☐ Children and Youth at Risk of Juvenile Justice Involvement

**For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

# MHSA PEI Executive Summary Submitted by Seneca Center

## Organizational Background

Since its inception in 1985, Seneca Center has dedicated itself to addressing the complex and multiple needs of children with serious emotional and behavioral challenges and their families. Seneca has been a certified Medi-Cal mental health services provider in Alameda County since 1992 and is now one of the leading CBO contractors with Alameda County Behavioral Health Care Services. Seneca's mental health treatment programs are critical components within the County's system of care for indigent children and youth diagnosed with serious emotional disturbance. Seneca's continuum of mental health services for Alameda County children and families includes:

- Nonpublic school-based day treatment services for students who reside throughout Alameda County;
- The Building Blocks Therapeutic Preschool for emotionally troubled younger children and their parents/caregivers;
- Public school-based mental health services for students residing in the Berkeley, Hayward and Oakland school districts, as well as students served by the Alameda County Office of Education;
- Mobile response and therapeutic behavioral services for Alameda County children and youth at risk of psychiatric hospitalization, out-of-home placement, and/or movement to a higher level of care;
- Willow Rock Center crisis response services for adolescents in serious distress;
- Short-term, residentially-based assessment and diagnostic services for foster children identified by Alameda County Social Services as needing higher levels of care;
- Long-term, residentially-based services for children whose behaviors have not responded to care and treatment in other high-level settings (including psychiatric hospitalization).

## Data Sources

Mental health agency administrators, policy makers, consumers, and family members are often frustrated with the inadequacies of psychiatric hospital treatment, which often results in a revolving door for many people diagnosed with mental health disorders. In Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization (2004), David S. Heath asserts that "short-term, mobile, intensive treatment in the patient's home with staff available 24 hours a day is emerging as the most versatile and effective alternative to hospital and is applicable to a broad range of patients with acute mental disorders who would otherwise need admission" (p. xvi). Mr. Heath makes a compelling case for this assertion, particularly with his review of 14 studies of which all but one found that mobile crisis treatment reduces hospital bed usage, is less expensive, equally effective, and much preferred over inpatient care by clients.

The experience of Seneca Center's Mobile Response Team (MRT) program in Contra Costa County reinforces Mr. Heath's conclusion, with its 85 percent success rate in stabilizing youth

and families in serious distress. In regard to the MHSA Prevention and Early Intervention planning efforts in Alameda County, it is important to note that Seneca's Contra Costa MRT targets several of the **priority populations** and **key community mental health needs** emphasized in the PEI Program and Expenditure Guidelines.

**Populations currently served by the Contra Costa MRT include:**

**Underserved Cultural Populations:** Within Contra Costa, Seneca's MRT has experienced a high degree of success addressing the crisis stabilization needs of an ethnically/racially diverse population of youth and families who are eligible for Medi-Cal. In addition, a recent article on the Baltimore Crisis Response program concluded that "to better serve poor urban African-Americans, a comprehensive, community-based, mobile-crisis intervention approach is needed." See Llewellyn J. Cornelius; Gaynell M. Simpson; Laura Ting; Edgar Wiggins; and Sharon Lipford (February 2003). Reach Out and I'll Be There: Mental Health Crisis Intervention and Mobile Outreach Services to Urban African Americans; *Health & Social Work*; Volume 28, Number 1, Pages 74-78.

Many of the young people with whom MRT intervenes are youth who are questioning their sexuality and/or are experiencing depression and anxiety symptoms related to their sexual identity. Gay, lesbian, transgender and questioning youth are at high risk for suicide. These young people are often homeless and not connected to services and/or support networks. The Contra Costa MRT program is able to serve youth who are homeless, traveling to a safe, community setting in the county wherever the child may be in order to provide immediate crisis counseling, as well as linkages to ongoing community resources and supports.

**Individuals Experiencing Onset of Serious Psychiatric Illness:** Many youth and families are reluctant to seek help, especially if/when they may be confused or ashamed by the odd, dangerous, and/or confusing behaviors being presented by the young people. MRT is able to meet with youth and families in their homes to provide a thorough assessment and recommendations for seeking help or treatment, without the threat of having to commit to a particular plan for treatment or having to take a child to the hospital (MRT assists in hospitalizations when assessed as necessary).

Each MRT team provides psycho-educational support in a non-judgmental manner and specifies with the caregivers what may or may not need to be addressed immediately or in the near future, along with recommended treatment/service options. Much of the focus is on helping the family to understand the process and benefit from a "first positive experience" of mental health providers, with the goal of increasing their comfort level and knowledge base in order to advocate for their child. When a youth or family is already in crisis, the resulting anxiety provides a window of opportunity where the family and/or youth is in enough distress to seek the services they may need.

**Children/Youth in Stressed Families:** Currently MRT is able to provide services in the homes of families recently referred to Child and Family Services through the Emergency Response Unit. Many of these parents are open to the mental health intervention and report a sense of isolation and desperation in seeking help with their children's behaviors and emotional issues. Most families are unaware of the resources in their community and are appreciative of the opportunity to work with mental health professionals to connect with available services. The mobility of the program allows staff to work with parents with multiple children who often do not have the means or ability to attend mental health appointments, thereby avoiding their becoming overwhelmed by the challenges of setting up services for their children. The linkage aspect of the MRT program has been essential in connecting isolated and overwhelmed parents with resources and supports in their communities.

**Trauma Exposed:** In Contra Costa County, the MRT program has made a commitment to provide immediate crisis grief counseling to youth who have witnessed a parent's death by suicide/domestic violence or other traumatic situation. This past year, MRT served some of the families living in Richmond who were victims of shootings. All were offered immediate in-home grief counseling, follow-up counseling, and linkage to longer-term mental health services. MRT services are often requested when a young person has recently been raped. Many youth with a history of trauma are at high-risk for being re-traumatized. Many of these teens are reluctant to participate in long-term services, yet are often open to receiving mental health services immediately after the trauma for short periods of time.

## Recommendations

Within Alameda County, Seneca's Mobile Response Team (MRT) is limited to responding to the following populations of youth in crisis:

- Alameda County dependent youth with Full-Scope Medi-Cal.
- Transition age youth with Full-Scope Medi-Cal.
- Youth at the 5150 ports with Full-Scope Medi-Cal.

Seneca Center recommends that the Alameda County PEI Planning Panels review the scope and impact of the agency's Mobile Response Team (MRT) program in Contra Costa County as it considers options for more effectively serving the priority populations for MHSA Prevention and Early Intervention. The MRT provides young people and their families with almost immediate crisis intervention and stabilization in their homes and neighborhoods, as well as linkages with available community resources for ongoing support. Also of critical importance is MRT's collateral work with:

- Multi-generational family issues, such as where young people are being raised by grandparents or great grandparents.
- Schools, such as working with school counselors to assess children at school, providing pscho-education to teachers, advocating for IEPs, etc.
- Other providers, such as group homes, foster family agencies, clinics, therapists, etc.

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable)___Seneca Center and Niroga Institute_____
Contact Person_____Ken Berrick and Bidyut K. Bose_____
Address ___Seneca Center, 15942 Foothill Blvd, San Leandro, CA 94578_____
___Niroga Institute, 3101 Arizona Street, Oakland, CA 94602_____
Phone No./ Email address_510.317.1444, ken@senecacenter.org; 510.508.1653, bk@niroga.org_____

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

☒ Children & Youth (0-18) ☒ Transition Age Youth (14-25) ❒ Adults (18-59) ❒ Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
☒ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

☒ Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
☒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

# Executive Summary

## Organizational Background

- Seneca Center
    - Since its inception in 1985, Seneca Center has dedicated itself to addressing the complex and multiple needs of children with serious emotional and behavioral challenges and their families. Seneca has been a certified Medi-Cal mental health services provider in Alameda County since 1992 and is now one of the leading CBO contractors with Alameda County Behavioral Health Care Services. Seneca's mental health treatment programs are critical components within the County's system of care for indigent children and youth diagnosed with serious emotional disturbance. The agency's continuum of mental health services for Alameda County children and families includes public school-based mental health services, preschool day treatment, mobile crisis response, therapeutic behavioral services (TBS), 23-hour crisis response services (Willow Rock Center), short-term and long-term residentially based services. Seneca collaborates with the Niroga Institute at Rock LaFleche Community School in order to engage at-risk youth in mindfulness practices.
- Niroga Institute
    - Niroga Institute is dedicated to improving the health and well-being of at-risk and underserved individuals and families through the holistic practices of Yoga, Breathwork and Meditation. Engaging in community outreach, education, and research, Niroga provides affordable, high quality Yoga instruction and Yoga therapy through a variety of partner institutions, such as Alameda County Juvenile Hall, schools and alternative schools, homeless shelters, and Parks & Recreation Centers. Seeing the effects of our work on incarcerated youth, Dr. Janice Thomas, Clinical Psychologist in the Guidance Clinic at ACJJC noted, "Yoga helps victims of abuse develop positive coping strategies by helping them learn how to regulate affect, and to interrupt the destabilized state that leads to acting out and violence against others."
    - Under contract with the Alameda County Health Care Services Agency (HCSA) and Probation Department, Niroga has been bringing mindfulness practices to Alameda County Juvenile Hall for the past 18 months. The nature and the magnitude (5 days/week) of the program make it unique nationally, and the program has received an overwhelmingly positive response from incarcerated youth, Juvenile Hall staff, and administration. Providing funding for program expansion to a second unit at Juvenile Hall and starting a program at Camp Sweeney, William Fenton, Deputy Chief of Probation, said, "My Probation Officers in the field are reporting that the kids are taking Yoga outside Juvenile Hall with them. We need to support this work."
    - In a partnership with the Bay Area Black United Fund (BABUF), and with resources from the Department of Public Health, Niroga Institute is training African American young adults to become Certified Yoga Teachers, prepared to serve their own communities. BABUF is making the Niroga program a cornerstone of their African American Health Initiative. Alex Briscoe, Assistant Director of HCSA, says, "I am highly impressed with Niroga's work, and their ability to bring the practice of integrative physical arts to marginalized communities. Niroga is quickly developing an unprecedented track record in bringing Yoga to young people who have never been exposed to Yoga."

## Data Sources

- Findings on the effects of mindfulness practices on:
    - PTSD: Several recent studies have shown beneficial effects of mindfulness practices on PTSD, borderline personality disorder, and bipolar disorder, commonly showing up in youth exposed to abuse or violence:

        - Bradley, SD et al. A Mental Health Intervention for Schoolchildren Exposed to Violence. JAMA, August 6, 2003- Vol 290, No. 5.
        - Brown RP, Gerbarg PL. J Altern Complement Med. 2005 Aug;11(4):711-7. Sudarshan Kriya Yogic breathing in the treatment of stress, anxiety, and depression. Part II--clinical applications and guidelines. Columbia College of Physicians and Surgeons, New York, NY, USA.
        - Gordon, JS et al. Treatment of PTSD in Postwar Kosovo High School Students Using Mind-Body Skills Groups. Journal of Traumatic Stress, Vol. 17, No. 2, April 2004, pp. 143-147.
        - Roth B, Stanley TW.Altern Ther Health Med. 2002 Jan-Feb;8(1):60-2, 64-6. Mindfulness-based stress reduction and healthcare utilization in the inner city: preliminary findings.
        - Wall, RB. Tai Chi and mindfulness-based stress reduction in a Boston Public Middle School. J Pediatr Health Care. 2005 Jul-Aug;19(4):230-7
    - Psychopathology: Niroga has shown statistically significant decline in stress and self-control in incarcerated youth, through regular practice of yoga, breathing techniques, and meditation:
        - B.K. Bose & Connie Philipp (January 2007), Effects of a Healing Yoga Protocol on Stress Resilience in Incarcerated Youth, Research Abstract, *Symposium on Yoga Therapy and Research*, International Association of Yoga Therapists (IAYT), and Internal Report for HCSA and Alameda County Juvenile Justice Center (ACJJC)
        - Feedback on Niroga mindfulness program at ACJJC:
            - Several Incarcerated Youth: "I learned how to control my body and how to breathe calmly." "Breathe and let go. I felt relaxed, calm, and complete." "It helped me get inside. Breathing right helps you think right." "I learned a lot from it – whenever I get mad, just start breathing; and I actually like yoga!" "Wow, if everyone did yoga, there would not be so much violence in the world!"
            - Staff: One girl in particular initially hated yoga. Although she initially rejected the mat during an offer of an individual yoga session, she was eventually able to see from this act her own refusal to calm down. She had practiced yoga in group sessions, and thus, she had this experience to reflect upon during therapy. In the past, she had used heroin, self-mutilation, and prostitution to calm herself down, but she was eventually able to see that she could calm herself in less harmful ways including practicing various yoga poses. Her ability to develop internal awareness and to self-regulate her emotional state was a turning point. Affect regulation is a sign of normal psychological functioning and well-being. I have observed yoga being effectively used to help youth restore their breath and calm themselves and thus move toward affect regulation. *Janice Thomas, Ph.D.*, Clinical Psychologist, Guidance Clinic

## Recommendations for More Effectively Serving MHSA PEI Priority Populations

- At-risk children, youth: Develop an architecture for lasting community transformation, inoculating self-transformative life skills into an entire generation of at-risk children and youth, from Kindergarten through 12th grade, wherever they are, including Juvenile Hall, group homes, schools and alternative schools, and Parks and Recreation centers (turning these into distributed centers for integral development, with life skills, health care, academic mentoring, and job skills).
- Young adult populations: Select and train minority young adults in life skills, to become peer leaders and community health educators, systematically disseminating these skills in natural community settings with cultural competence. The training also acts as a job-skills program for these young adults, even as

they engage in serving their communities, promoting positive cognitive, social, and emotional development, and encouraging a state of health and well-being.

- Underserved Cultural Populations: Bring these self-transformative life skills to schools and alternative schools, with 50% or more free/reduced lunches. Systematically developing capability to use a variety of focusing and engagement strategies to address the diversity of learners, and the substantial disparities in education outcomes.
- Children and Youth already in, or at Risk of Juvenile Justice Involvement: We need to provide these programs consistently in every unit of Juvenile Hall (max capacity of 360, with average length of stay of 19 days, for a total of 7,000 youth, placed in 12 units of 30 each. Preserving continuity of care and attention, these mindfulness programs need to be offered at Camp Sweeny, and at group homes, where youth are either sentenced, or have serious emotional disturbances and behavior problems, or are there because they are abandoned, homeless, abused, or neglected.
- Proposed Implementation Goals, Desired Outcomes, and Evaluation
    - Implementation
        - Systematically disseminate life skills through a comprehensive multi-component discipline of yoga, breathing techniques, and meditation
        - Train minority young adults , together with school teachers, parent volunteers, as well as mental health staff, to learn these life skills and serve their constituencies
    - Desired Outcomes
        - Individual and Family Outcomes
            - stress resilience and anger management
            - focus and attention
            - self-control and self-esteem
        - Program and System Outcomes
            - Favorable changes in utilization costs and compliance
            - Decreased recidivism rates and community crime and violence
            - Increased awareness of the power and potential of personal transformation
        - Long-Term Community Outcomes
            - Effect lasting transformation in one generation, carried over into succeeding generations
            - Forge strong public-private partnerships to ensure and sustain system change
    - Evaluation
        - Pre-intervention and post-intervention data should be collected and analyzed, through a combination of qualitative survey instruments, as well as validated psychometric scales, to measure changes in stress (Perceived Stress Scale, PSS10), self-control (Tangney Self Control Scale, TSCS13), self-esteem (Tosenberg Self Esteem Scale, RSES10), and self-awareness (Mindful Attention Awareness Scale, MAAS15)
        - Recidivism rates in Juvenile Hall, rehab centers such as Thunder Road, as well as group homes, need to be studied, and trends with mindfulness practices compared to baseline data
        - Effects of pervasive application of this innovative PEI on community crime and violence, need to be studied one community at a time; effects of these types of programs on classroom engagement and referrals to the Principal (measures of classroom management and behavior problems at school), should be investigated
        - Utilization of mental health treatment services of those exposed to these programs, should be compared to those who are not (control group); additionally, frequency of common chronic conditions and related impact on public and behavioral health costs and services, should be investigated

# Oakland Arise!

Community Engagement for Integral Health and Development of At-risk Youth

Niroga® Institute, 3101 Arizona Street, Oakland, CA 94602

"Now is the time to lift our nation from the quicksand of racial injustice to the solid rock of brotherhood. Now is the time to make justice a reality for all of God's children."
*Rev. Martin Luther King, "I have a dream," August 28, 1963*

- **Goal**: Teach self-transformative life skills to **an entire generation** of at-risk youth – between the ages of 6 and 18 years (Kindergarten through 12th grade)
  - Alameda County Juvenile Hall and Camp Sweeney - incarcerated youth
  - Group Homes for vulnerable youth and children
    - sentenced youth; those with emotional disturbances and disruptive behaviors
    - abused, neglected, and abandoned children; youth dealing with substance abuse
  - Oakland schools with 50% or more free or reduced lunches – K-12 and after-school
  - Oakland Parks and Recreation (OPR) centers – 36 sites

- **Impact**: Complement, enhance, integrate, and enable collaborative efforts
  - Physical health – metabolic syndrome, hypertension, CAD/PAD, asthma, stress
  - Academic potential - increased focus, attention, and concentration
  - Resiliency skills and healthy life choices - self-control and self-awareness
  - Violence prevention - anger and stress management
  - Program impact on public and behavioral health, education, and social justice
  - Program impact on youth development and community crime and violence
  - Increased capacity of community leadership to provide life skills and mindfulness instruction for self-transformation

- **Need**: Social Return on Investment (SROI) annually is ~ 1000X ($6Billion/$6Million)
  - Public health budget for Alameda County is $100M/yr, and Health Care Services Agency is $600M/yr (includes Behavioral Health and Indigent Health)
  - It costs Alameda County $150K/yr to keep one youth in Juvenile Hall (Chief Blevins); there are ~ 300 youth in Juvenile Hall and ~ 80 in Camp Sweeney
  - Societal cost of juvenile delinquency is $500K/youth/yr, and adult criminality is $1.5M/adult/yr (Bureau of Justice Statistics)
  - It costs $50K to triage one gunshot wound (Chief, Highland General Hospital); homicide is the leading cause of death among 15-24 year-old African Americans

- **Methodology**: direct service to children, and train community leaders and volunteer health advocates, as well as school teachers and institutional staff and administration
  - Comprehensive multi-component discipline of Healing Yoga, breathing techniques, and mindfulness/meditation
  - Expand life-skills classes in schools, OPR centers, Juvenile Hall and Camp Sweeney
  - Train Critical Mass Health Coordinators (CMHC) in life skills and mindfulness practices, to place and provide instruction throughout the community
  - Train selected youth in life skills and mindfulness practices to build capacity for peer-to-peer instruction throughout the community
  - Train school teachers and mental health staff in mindfulness practices for stress resilience and classroom management and complement group process

- **Evaluation**: Internal and independent academic evaluation to assess program effectiveness
  - Psychometric evaluation tools and qualitative surveys developed by Niroga Institute
  - UC Berkeley and UC Davis Schools of Public Health; UCSF Dept. of Biostatistics
  - UC Berkeley Department of Education and UC Berkeley School of Social Welfare
  - Alameda County Department of Public Health (ACPHD), Behavioral Health Care Services (BHCS) and Alameda County Health Care Services Agency (HCSA)

- **Annual Budget** [$ 6Million]: Program delivery to 8,000 youth, training to 750, and evaluation
  - Incarcerated youth [$ 0.80Million]:
    - Juvenile Hall – 12 units, 2 classes/day, 5 days/wk; $624K/yr
    - Camp Sweeney – 6 groups, 1 class/day, 5 days/wk; $156K/yr
  - Group Homes [$ 0.80Million] – 24 sites, 2 classes/day, 3 days/week
  - At-risk youth in Oakland schools [$ 2.0Million] – Oakland Success/OCASA sites
    - 50 elementary, 40 middle, and 30 high schools with 50% or more free/reduced lunches; 540 classrooms, 20min/class, 3 days/wk
  - Community: OPR [$ 1.20Million] – 36 sites, 2 classes/day, 3 days/week
  - Training [$ 0.30Million]:
    - Train 50 CMHC and 50 Youth Leaders (mentorship) in mindfulness and life skills practices every year; $50K
    - Train 10 CMHC and 10 Youth Leaders (mentorship) to become Certified Yoga Teachers, members of Niroga Yoga Corps™; $100K
    - Train 550 school teachers in stress resilience and classroom management, and 80 institutional staff in group homes, every year; $150K
  - Research Analysis [$ 0.30Million]: 4 x $75K for 4 Research Analysts to evaluate program effectiveness in public & behavioral health, education, and community crime/violence
  - Administrative and indirect expenses: $ 0.60Million (10%)
  - Unit cost for program delivery: 8,000 youth at 15 classes per youth, $750/youth; compare with Harlem Children's Zone: 60 city blocks, 8,600 kids, $36.3M, $4,220.93/youth

- **Partners**: Build inter-agency collaboration and forge strong public-private partnerships
  - Public stakeholders: Alameda County Public Health Department (ACPHD) and Health Care Services Agency (HCSA), Probation, and Education (OUSD/ACOE)
  - Private partners: Corporations, Foundations, Individuals, NGOs
    - Kaiser Permanente, and other corporations headquartered in Oakland
    - San Francisco Foundation, East Bay Community Foundation, The California Endowment, Robert Wood Johnson Foundation, and other Foundations
    - Celebrity sports stars and major Bay Area philanthropists
    - Niroga Institute, Bay Area Black United Fund, International Black Yoga Teachers Association, Community Oriented Correctional Health Services (COCHS), Seneca Center, Prescott-Joseph Center for Community Enhancement (PJCCE), & others

- **Implementation**: Ramp up over 5 years, linearly increasing program delivery and training
  - Yrs 1&2 [$ 3.0M]: Demonstrate effectiveness; build partnerships; generate awareness
  - Yrs 3&4 [$ 4.5M]: Expand services; evaluate program impact; refine methodology
  - Years 5 to 12 [$ 6.0M]: Build and maintain capacity; develop policy recommendations

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President and Executive Director, Niroga® Institute ( www.niroga.org )
[ Please watch Niroga's 8-minute youth development video at http://www.niroga.org/media.html ]

# ACBHCS Study Group on Early Intervention
# At the Onset of Psychosis

**December 12, 2007**

**Summary:** The Study Group on Early Intervention for the Onset of Psychosis has examined a variety of national and international programs and evidence-based practices for proactively addressing and preventing the onset of serious and persistent mental health disorders associated with psychosis. To replace a "fail first" model in which consumers must already have received a diagnosis and had multiple contacts with the mental health system before they can receive non-emergency support, the Study Group proposes that three programs/components be established. Each of these strategies is targeted to fill a current service gap in the County in the approach to and treatment of psychosis associated with the onset of a serious and persistent mental health disorder.

| Strategy | Target Population Served/ Service Time Frame | Summary of Proposed Services | Programs/ models for proposed effort |
|---|---|---|---|
| A. Community outreach, education and screening | Persons at-risk for psychosis and their families; professionals who work with young people at risk such as primary care physicians, teachers, school psychologists, ministers, law enforcement agents, and the community at large.<br><br>Service time frame: brief or ongoing. | ▪ Organizes and delivers community education and local media campaign providing articles, interviews, presentations and educational forums about first onset psychoses in youth and young adults<br>▪ Conducts targeted outreach to individuals and institutions likely to come in contact with young persons who may experience psychosis;<br>▪ Provides preliminary assessments, crisis intervention, information and assistance in arranging for further assessments and treatment service referrals | PACE, TIPS, EAST, PIERS |
| B. Community-based support with clinical and social supportive services for young people and their families and caregivers | Individual youth and young adults (and their families/ caregivers) who are experiencing psychotic symptoms associated with the onset of a potentially serious and persistent mental health disorder, and whose duration of untreated psychosis is less than two years.<br><br>Service time frame: Maximum two years | ▪ Provides individual and group support to families and other care givers concerned for loved ones<br>▪ Assesses individuals interested in program and develops treatment plan<br>▪ Provides individualized case management to young people enrolled in the program<br>▪ Provides crisis intervention and stabilization<br>▪ Offers ongoing counseling to support individual and family coping and recovery<br>▪ Offers clinical services supporting low or no dose medication<br>▪ Provides supported education/supportive employment services to allow young people to return to work or school as quickly as possible<br>▪ Provides family support including family psycho education, group and individual family support<br>▪ Substance use services<br>▪ Peer support | EPPIC, EAST, UCLA, PIERS |

| | | | |
|---|---|---|---|
| C. Short-term residential site for persons experiencing an acute psychotic episode | Persons actively experiencing a first or second psychotic episode<br><br>Time period: Average stay 8-10 weeks, Maximum period 4 months | ▪ Provides a 24/7 residential safe space with support from clinical and non-clinical staff to move through the acute state of the illness<br>▪ Social milieu focus rather than clinical treatment; supports residents in exploring and attempting to understand their experience of psychosis, with or without the use of medication<br>▪ Supports maintaining role function as possible and planning for return to external roles<br>▪ Provides the opportunity to delay or avoid beginning medication unless requested by consumer | Soteria, Diabysis, Soteria-Bern |

Because of differences in focus, approach and staffing, each of the two treatment components offered may be operated by different providers. The Study Group advocates that although functionally separate, they be designed to coordinate with one another and with the Community Outreach and Support component, which may act as a front door to the both the community-based outpatient program and the residential option. All three contribute to strategies believed to comprise the array of services and choices that are needed to transform the mental health system and its linkage to the broader community which it serves.

## I. The Need for Programs in Alameda County to Address the First On-Set of Psychosis

Although the incidence of psychotic and particularly schizophrenic disorders is low compared to other serious mental disorders (estimated to be between 1-2% of the population), psychosis is one of the most disabling mental conditions. Psychotic disorders can severely impact human development and social, educational and community functioning. Individuals experiencing persistent psychoses are more likely to receive public assistance, have difficulty securing and maintaining employment, and to become involved in the criminal justice system. Those experiencing psychosis for the first time often go untreated or often fail to engage in ongoing services. In very rare instances, such individuals have become involved in tragic and highly publicized instances of violence. The duration of untreated psychosis is associated with greater severity in symptoms, lower rates of remission and poorer social functioning. The lifetime risk of suicide is particularly noteworthy in that approximately 50% of those with psychotic disorders attempt suicide in their lifetime and nearly one in ten complete a suicide. The risk is very high among those experiencing their first psychotic break, with one international study finding that more than 15% of participants in an early psychosis program attempted suicide before beginning treatment.

The current mental health treatment system functions as a “fail first” model, meaning that people with serious mental illness must have had multiple crises, often seeing the building blocks of their lives crumble, before they are eligible to receive ongoing treatment and services. By the time consumers become eligible for the services that they need, serious mental illness has generally become severe, persistent, and disabling. Opportunities to return to work, complete school and maintain lives that are personally satisfying and independent have been dramatically reduced or lost altogether. Psychotic symptoms associated with the onset of a potentially serious and persistent mental health disorder most

commonly emerge among teenagers and young adults, however few services in Alameda County are in place to serve this population with age-appropriate and culturally competent services. Early intervention with persons experiencing or at highest risk for experiencing their first episode of psychosis is designed to reduce the incidence and severity of psychotic illnesses such as schizophrenia. Education and early intervention utilizing evidence-based practices has recently been shown to be a well regarded and cost-effective service in combating stigma and reducing the duration of untreated psychoses in other communities. There are no early intervention programs offering these kinds of evidence-based services in Alameda County.

There is very little public information about the warning signs of emerging psychosis available to parents and professionals in Alameda County. Information and public education is needed to inform primary care physicians, teachers, and law enforcement officials about the signs and symptoms of emerging psychosis. Without knowledge of the existence of a "prodromal" period preceding psychosis in most persons who go on to develop a serious mental health disorder, families and institutions often either miss or misinterpret warning signs. Young people who could use assistance identifying and managing their condition are instead subject to school failure, criminal justice contact, increased drug use, and other problems and pressures that decrease their lifetime possibilities at the time when most young people are developing a path for their future.

Based upon local planning estimates of the underutilization of services by both transitional age youth and ethnic minorities, it is very likely that young people from underserved communities, especially Asian/Pacific Islanders, Latinos, and African-Americans, are even less likely than their white peers to be identified early or treated appropriately for symptoms of psychosis. Information and support or treatment programs must be designed to reach historically underserved communities, and to ensure that the services provided are language accessible and culturally competent to reach and assist these communities.

## II. Proposed Strategies

To address these gaps in Alameda County, the Study Group proposes three distinct but coordinated strategies or components for the prevention and early intervention ~~in~~ of psychoses associated with the onset of a serious mental health disorder. The objective of proposing three strategies is:

- To, as much as possible, prevent serious mental illness from becoming chronic and disabling,
- to intervene early with the goal of full recovery and maximum quality of life for persons affected, and
- to transform the system through providing a range of choices to consumers and families, including information that there is diverse and evolving opinion about the causes, definitions, diagnoses and treatment of mental illness.

The services and primary outreach proposed will be designed to engage underserved and low-income communities. However, recognizing the long-term cost consequences to the entire mental health system, the individuals affected, and to society, of untreated or uncontrolled schizophrenia, services should be made available to all individuals and families needing support.

## Strategy 1: Community Education, Outreach and Screening Services

The community outreach, education and screening component will provide information and education to individuals and institutions likely to come in contact with high risk youth, and will provide direct support for affected individuals, family members and caregivers trying to decide what steps to take at the time of early signs and symptoms which may indicate the emergence of a psychotic illness. This program has three primary components:

**A. Targeted Outreach and Education**: this aspect of the program will provide public education, and targeted information about psychosis to educate and train the provider community, school professionals, law enforcement officials, and other key service personnel who encounter young persons in the early stages of deterioration toward psychosis. Activities will include:

- Developing tools such as a user-friendly website and printed materials which can be used through mailings to schools and families
- Conducting outreach and offering educational presentations and training for professionals such as pediatricians, family practitioners, mental health professionals, educators, school psychologists and special services staff, and law enforcement officials, and to high risk groups and their families including graduate students, high school health class students and parent groups to be better prepared to accurately identify, young people who are manifesting either prodromal (early, pre-illness signs) or active symptoms and signs of schizophrenia and other major psychotic disorders.

The resources should include information indicating that there is a diversity of opinion regarding the best strategies and provide access to alternative sources of information.

Portions of this effort may be coordinated with the "Campaign for Social Inclusion" anti-stigma/education for the whole community and with the services provided by the Family Education Resource Center, but the primary effort will be specific to helping families and professionals recognize the specific warning signs of psychosis and to learn to respond and refer for services. Staffing should include consumers and family members as part of the education and outreach component.

**B. Preliminary Screening and Referral:** Screening will be conducted in a non-threatening, non-labeling way that seeks to rule out other potential causes of the behaviors, such as drug use, before referring interested persons for assessment, more intensive support and or treatment. Working with the consumer and any family member/ support persons, the program will advise the consumer and family on all options for more intensive support/treatment. Referrals to the programs described below will then be made based on the consumers expressed wishes.

## Strategy 2: Community-Based Support & Treatment Services

This strategy proposes creating an interdisciplinary team to work directly with youth and young adults who have been experiencing psychotic symptoms and have been found to be at risk for developing a serious and persistent mental health disorder. The focus of the various services proposed is to meet young people where they are and to assist them in resuming age-appropriate activities and functioning as quickly as possible through a variety of supportive services while also providing both education and support their families. The

emphasis of treatment is on managing symptoms and role fulfillment rather than diagnosis. Key services that this program offers are:

## A. Pre-enrollment Services

- **Family and consumer support:** This component will offer a safe and welcoming place that people can go either by appointment or on a drop-in basis to receive additional information, consultation on options, and social support. This place will be seen as the "one-stop" or front door for families and individuals concerned about warning signs which may signal the development of psychosis. This component may be offered in connection with, or even as a part of, the Family Resource Center.

  Persons seeking support at this program will receive information, and support to address their concerns, including opportunities for individual consultation and group support. The Center will provide:
  - Specific information to individuals and families about the common indicators and possible impact and consequences of untreated psychosis.
  - information about how to cope with social stigma, discrimination or isolation,
  - Strategies for improving functioning including health, nutrition and wellness skills training,
  - Counseling, including peer counseling, to support youth and families during critical early period and facilitate connection to appropriate treatment services.

  These types of support and information may be offered to a person who is at-risk or exhibiting symptoms prior to their having been formally assessed or diagnosed, and may be offered to family members or other concerned individuals even if the person of concern has not decided to seek any type of assistance.

- **Assessment:** A thorough clinical assessment will be offered to more clearly understand the nature of the individual's psychosis and how it is being experienced, to differentiate it from other possible conditions or causes and to determine which services or referrals may be offered. Assessments include evaluations of: familial history, antecedent conditions, medical and co-occurring conditions, the developmental, cognitive emotional and behavioral impact of the psychosis, current stressors, the role of the family in recovery and the various strengths and goals of the individual and how they might best be used to engage them and to form a recovery plan and focus for the work to be done.

## B. Services for Enrolled Participants

- **Individualized Case management:** Staff work directly with each enrolled participant to provide information about psychosis, assist participants to develop and achieve personal goals, and facilitate access to other components of the program and outside services
- **Family Education and Family Counseling:** Provides education to families for learning about psychotic illness, treatments, coping strategies and stress reduction, and provides a positive, sharing environment in which families of participants can help and support one another in multi-family groups or, when necessary, through individual family counseling.

- **Supported education/ employment:** Offers support and assistance to participants in planning, going to school, completing other training and/or obtaining and retaining employment. An employment specialist supports participants in their choices and helps to manage issues that arise in school or on the job performance. A job developer works with employers to create work opportunities for participants in community-based jobs. This aspect is a critical component and a major focus of the program and its primary goals for participants to "resume role functioning" quickly.
- **Medical services:** Provides medical screening and psychiatric support including information about medication and drug treatment based on an open, transparent and collaborative approach. Emphasis is placed on the individual's interest, desire and informed choice regarding the use of medication. Medication may not necessarily mean anti-psychotics and could include anti-anxiety, sleep restoring or other medications. For those choosing medication, focus is on starting low, going slow and managing side effects, including nutritional counseling and weight management
- **Crisis intervention and stabilization**
- **Counseling:** Individual and group counseling and cognitive behavior therapy to address the specific and unique issues that impact recovery and support common goals
- **Substance abuse counseling**
- **Cognitive interventions:** program provides assistance to participants for developing and practicing strategies to increase attention, concentration, memory, problem solving skills and anger management.
- **Stress reduction and complementary healing:** practices such as Yoga and meditation
- **Creative therapies** such as art, music and other creating exploration with the goal of deepening self-understanding and expression
- **Peer Support**: peer mentors from among those who have participated in the program or have completed the program can provide will serve as role models offering information and support on a peer basis to persons entering the program.

This program (except for the family and consumer support component) is enrollment-based, relies on a low staff-to client ratio and is anticipated to serve about 50-60 young people at any given time. Duration of services is expected to be approximately two years, although intensity declines as participants' exhibit significant recovery and the ability to better manage their lives.

The Study Group recommends that the employment services offered and the employment specialist in this program be linked to and coordinate with the BHCS Vocational program to the greatest extent possible to maximize relationships with community colleges, other training institutions, and with community-based employers. Since the Vocational program is being targeted at this point to BHCS service team participants, creating a link with this program will need to be developed specifically.

## Strategy 3: Short-term Residential Program

This program provides a small, short-term residential milieu with 24 hour a day, 7 day a week staff to work with and support persons who are experiencing active psychotic symptoms for the first or second time to move through the acute stage of the illness. The program is

designed to remove participants from stressors which are linked to psychosis and support them in their own exploration of their experience, without medication if they choose, to develop insights, and a personal understanding of their experience in the context of a homelike, quiet, protective, and tolerant social environment. When appropriate, the program may serve as a diversion from acute hospitalization or as respite for individuals most in need of the time and place to better understand and learn to manage their psychotic symptoms and experience.

This residential option differs from conventional treatment in that it uses a psychosocial approach and incorporates complementary modalities such as stress reduction practices including psycho-therapy, meditation and yoga, and creative expression such as art and music. While residents may take medication, the treatment rests primarily in the environment and personal relationships and supports that are fostered there. For some consumers, medication is not assumed to be necessary and may even be viewed as an impediment to recovery. The line and interactive staff will be people with personal qualities/competencies to maintain a helpful, hopeful recovery oriented environment. They will not necessarily be licensed mental health workers (though staff may be drawn from psychology and social work schools and may be interns). Staff will be overseen by qualified clinicians and a psychiatrist. Psychotherapy is not required but is available to residents who want it to help move the process and integrate insights that may emerge.

Daily activities in the house are determined by the choice of the residents. There is shared responsibility for the running the house and playing a part in a mutually-supportive community, with the distinction between experts and non-experts downplayed. Residents are encouraged to maintain a whole person self view and to maintain roles in society. Length of stay is projected at between 1 to 4 months with an average stay of 8-10 weeks. Discharge occurs when the person can resume usual roles outside of the house. Some individuals may benefit from subsequent referral to the community based program component for continued support with their recovery and resumption of life roles.

Residents are encouraged to continue with life activities as is appropriate and possible during their stay. House staff helps residents maintain community roles such as worker, student, spouse, family member.

The role of families and significant others is recognized, and strengthening these supports is actively encouraged/emphasized, including while their loved one is a resident. When strong family relationships are present, family members are welcome to visit and should be coordinated with and provided guidance in how to be constructive and collaborative in the recovery process Family members may also continue to receive support from the Community Outreach, Education and Support Program (a. above) while a loved one is residing in the House.

This program is expected to provide between 8 and 10 beds, and serve approximately 40-50 persons annually. Staffing is low-ration and intensive, and opportunities to link to schools for students seeking internships should be explored. The Study Group understands that there is interest on the part of consumer advocates in Contra Costa County in developing a similar program and recommends exploring the potential for collaboration on this effort. It is also possible that this program may be partially supportable through the MHSA funds for Innovations, capital funds, or other sources. Two similar proposals are currently in planning in Manhattan, NY and in Alaska.

## III. Anticipated Individual and System Outcomes

Taken together, the three strategies are intended to promote significant change in the practices and the outcomes for 1) the non-mental health systems that identify and refer potential participants to the programs, 2) for consumers and family members affected by psychosis, and 3) for introducing recovery-oriented prevention and early intervention strategies for the primary target population of the mental health system. Six key indicators of success include:

1. Timely community awareness and participation in helping prevent serious mental illnesses from becoming chronic and disabling through earlier identification and referral of persons at high-risk or exhibiting psychotic symptoms by "gatekeeper" or "feeder" systems such as schools and colleges, primary care providers and law enforcement agencies:
    - Primary care physicians and medical staff do a better job of identifying people at first break/high risk and know where to refer people
    - School systems do a better job identifying and referring people at risk
    - Criminal justice/law enforcement educated; reduction in people in CJ settings better served by Mental Health
    - Families relatives and friends

1. Decrease in ethnic disparities in accessing care:
    - Families and young people reached by the outreach component and served by the support programs reflect the diversity of the at-risk population
    - Outreach materials and follow up services are available in multiple languages
    - Participants report feeling comfortable with the services provided
    - Service providers reflect the diversity of the target population and demonstrate cultural competence

2. Greater consumer participation and choice in treatment and service decisions:
    - Consumers are included in the development of the program models and in their operation as staff, volunteers and on oversight bodies
    - All three programs are designed to focus on consumers making decisions for themselves with a range of prevention and early intervention strategies and models
    - Program participants identify less as being part of "the mental health system" while still receiving desired support/treatment for their condition(s)

3. Consumers have higher rates of recovery, returning to "role-typical" lives and self-reported satisfaction with quality of life:
    - Relapse rates are reduced by at least 50% and participants have lower rates of developing severe, persistent and disabling mental illness
    - Participants return to productive, satisfying lives as measured both by school and workforce participation rates and by self-reported quality of life measures
    - Consumers have fewer long-term health problems associated with schizophrenia and treatment, such as diabetes, depression, and early morbidity.

4. Families have more information and support to assist family members and to receive support:
    - Early Identification of warning signs of psychosis for family members and where to seek help
    - Families are connected to each other, and report receiving support and decrease isolation
    - More families are aligned with recovery goals and expectations and can support their loved one in making choices
    - Families report having additional options reduced conflict associated with supporting and managing the demands of youth in the early stages of mental illness
    - Family members are involved in the development and oversight of the programs, and as staff or volunteers as possible

5. The mental health system has fewer hospitalizations and referrals for intensive, ongoing treatment in the adult or TAY system of young people associated with psychotic symptoms associated with the onset of a potentially serious and persistent mental health disorder.

Each month in Alameda County two or more or individuals present at crisis services experiencing their first psychotic episode possibly associated with a serious mental illness 20 to 25 individuals are hospitalized with psychotic symptoms, and 12 to 15 referrals of seriously mentally ill transitional age youth are made to the TAT team. The Study Group proposals are intended to reduce the acute incidence of these disorders by increasing early identification and reducing the proportion of individuals who prolong the duration of untreated psychoses until they become acute disorders.

## IV. STUDY GROUP BACKGROUND

Members of the Study group were selected from a pool of applicants who attended a large kick of meeting in March 2007 and were selected to ensure representation from a variety of stakeholder groups. The Study Group met 11 times between April and October, 2007 and reviewed materials, heard presentations and discussed issues and alternatives for developing new program(s) in Alameda County.

*Consumers:* **Jay Mahler**, Consumer Director, BHCS, **Monroe King**, Pool of Champions and PEERS, **Maria Torres**, Pool of Champions

*Family members:* **Liz Rebensdorf**, NAMI, **Julie Testa**, Pleasanton Commission on Human Services, **Gigi Crowder**, BHCS

*Providers:* **Roger Daniels**, Fred Finch Youth Center*****, **Shelley Levin**, Telecare Corporation*****, **Roger Marsden**, Alameda County Social Services Agency, **Carla Danby**, ACBHCS

*Others* (Advocates, BHCS staff in key areas): **Peter Alevizos**, Adult Services Director, BHCS, **Michelle Burns**, TAY Director, BHCS, **Rick DeGette**, Vocational Services Director, BHCS, **Kathie Zatkin**, Alameda County Network of Mental Health Clients, *(views expressed were not necessarily those of the Network)*

*Facilitator:* **Katharine Gale**, Katharine Gale Consulting

*(*in order to avoid any conflict of interest , these members resigned from the Study Group when the group finished its research studying various models and before it began to develop and write its proposal ideas.)*

## Programs Studied or Reviewed by the Study Group:

The study group individually and/or collectively reviewed many articles, program descriptions, literature reviews and research studies. In addition to psychosocial interventions, the group reviewed the role and range of medication practices associated with the prevention and early intervention of the onset of serious psychotic mental disorders. The following internationally recognized programs, based mostly upon early intervention strategies, were reviewed in greater depth:

**EAST** (Oregon) – Study Group reviewed materials and attended presentation by Tamara Sales and EAST program staff; Follow up information was gathered from the EAST program by Roger Daniels and Michelle Burns.

**EPPIC** (Australia) – Study Group reviewed materials and heard presentation by group member Shelley Levin.

**PACE** (Australia) - Study Group reviewed materials and heard presentation by group member Shelley Levin.

**PIER** (Maine) – Study Group reviewed materials and one of the members of the study group (Michelle Burns) visited the program; Follow up information was gathered from the PEIR program by Carla Danby.

**Soteria House** (California, various International) – Study Group reviewed materials and a hosted a community presentation by two former consumers and a former staff member of two original model programs and a presentation of the model and its research by Prof. John Bola from USC. Follow up information was gathered from John Bola by Roger Marsden.

**UCLA** (California)– reviewed materials and hosted an open community presentation from Professors Keith Neuchterlein, Joseph Ventura and Luana Turner from a 20-year research and treatment program at UCLA; follow up information was gathered by from the UCLA staff by Peter Alevizos. Dr. Alevizos also made a site visit to UCLA to discuss details of their work.

**Columbia-Presbyterian Medical Center** - The group viewed a DVD of Dr. Robert Lieberman's work at Columbia University presenting on neurophathic evidence and pharmacotherapy in individuals experiencing their first episode of schizophrenic disorder presented at the May 2007 meeting of the American Psychiatric Association; this was followed by a dialogue with ACBHCS's Medical Director, Dr. Karl Adler on Dr. Lieberman's research.

The group also received a manuscript and presentation by Shelley Levine summarizing a literature review of First Onset research and guidelines for treatment programs internationally that she authored and which was later used by planning staff at the State Department of Mental Health's Office Prevention and Early Intervention.

In studying program models and examining available information, certain members of the group noted that it is sometimes difficult to find out the financial ties between pharmaceutical companies, advocacy groups, university researchers and/or others.

Submitted December 12, 2007

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) Alameda Health Consortium
Contact Person B. Patricia Barrera
Address 1320 Harbor Bay Parkway, Suite 250 Alameda, CA 94502

Phone No./ Email address 510-769-2235 patriciab@alamedahealthconsortium.org

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

X Children & Youth (0-18) X Transition Age Youth (14-25) X Adults (18-59) X Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

X Disparities in Access to Mental Health Services
X Psycho-Social Impact of Trauma
X At-Risk Children, Youth and Young Adult Populations
X Stigma and Discrimination
❒ Suicide Risk

Priority Populations

X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
X Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

## I.EXECUTIVE SUMMARY

### Section 1: Organizational Background:

The **Alameda Health Consortium** (AHC) is an association of eight community-based health centers that provide care to over 160,000 diverse and low-income individuals in Alameda County and operate over 35 primary care and social service sites in Northern, Central, Southern and Eastern Alameda County. Our member clinics are:

- **Asian Health Services**
- **Axis Community Health**
- **La Clinica de La Raza**
- **LifeLong Medical Care**
- **Native American Health Center**
- **Tiburcio Vasquez Health Center**
- **Tri-City Health Center**
- **West Oakland Health Council**

The Alameda Health Consortium serves as a convening and coordinating body for its member clinics. Founded over thirty years ago, the Consortium's mission is to work together with our member clinics and support the involvement of our communities in achieving comprehensive, accessible health care and improved health outcomes for everyone in Alameda County. Services provided by AHC to our clinics include health policy and planning, advocacy, program development and implementation, training, evaluation and other forms of technical assistance. For example, we have a policy and advocacy department and various programs including HIV ACCESS, Eligibility and Enrollment, emergency preparedness and access to health care for immigrants. In its over thirty years of existence the Consortium has served as an incubator for several special projects and programs that increase access to health care and improve health outcomes.

AHC also works closely with our sister organization, the Community Health Center Network – a full services practice management and managed care services organization – which the Consortium created about 10 years ago.

### Section II: Data Sources:

We have a variety of data sources that include the following:

- Community Health Center Network Data Warehouse
- Alameda Health Consortium member clinic data
- California OSHPD data
- Integrated Behavioral Care Project Focus Groups
- Frequent Users Program - outcome data
- Robert Wood Johnson Foundation Report – February 2007
- AHC Mental Health Workgroup – focus group discussions
- Assessment of mental health programs of AHC Member clinics
- Mental Health: Culture, Race, and Ethnicity – 2001
- Improving the quality of Health Care for Mental and Substance-Use Conditions – Institute of Medicine
- Other Published research data on integration

### Section III - Recommendations:

**1. Integrating mental health services within the primary care system and directing PEI funds to community based primary clinics.**
This recommendation meets the PEI goals in several ways:

- Integrated care would transform the system to better meet the needs of many Alameda County residents that may be suffering from mental health illness.
- Community based primary care clinics have a track record of preventing serious diseases or illnesses, as well as preventing aggravation of illnesses
- Programs and funding should focus on places where patients already go to receive care – community-based primary care clinics are a perfect example of an organization that patients already go to receive care.
- Community based primary care clinics serve the priority populations that have been targeted for this funding.
- Providing mental health services in an integrated setting reduces the potential for stigma and discrimination against individuals with mental illness.
- Community based primary care clinics also focus on supporting families experiencing health problems and concerns.

**2. Conduct screenings, assessments, and increase clinic capacity to conduct screenings, assessments and early interventions**

This recommendation meets the PEI goals in several ways:

- Conducting screenings and assessments, as well as early interventions in a primary care setting is a proven medical model in preventing aggravated cases of illness.
- Such efforts will increase prevention and response to early signs of emotional and behavioral health problems among specific at-risk populations, as well universal and selective target groups.
- Consistent screening and assessments would be to start reducing health disparities, including mental health disparities.
- Conducting more screening to the universal, specific or at risk populations would enable us to use data to measure health outcomes in the area of mental health.

*Please see the report below for a more in-depth justification for best practices, the recommendations and how the recommendations meet the purpose and goals of prevention and early intervention goals as described in the PEI guideline.*

## II.REPORT

The Mental Health Services Act represents an approach to the development of community based mental health services and supports for the residents of California. Prevention and Early Intervention funding is intended for programs that prevent the development or aggravation of serious mental illness and/or provide early interventions that will support individuals and families who are experiencing mental health problems and concerns. We are recommending the following focus areas for funding.

### Recommendation

**Integrating mental health services within the primary care system and directing PEI funds to community based primary clinics.**

This recommendation directly addresses the idea of transformation in the way an integrated approach would restructure the mental health system. There are a variety of reasons for supporting this recommendation. **First, integrated care would transform the system to better meet the needs of many Alameda County residents that may be suffering from mental health illness.** Historically,

both the mental health and primary care systems of care have worked as "silos" and for many patients, this may not be the best approach. Now is the time to change our system to better meet the needs of patients with mental health illness. While some of our member clinics have separate medical and behavioral health operations, there are many that have integrated models, have piloted integrated models or have plans for integrated models. Some of our member clinics have made strides toward integrating mental health into the primary care system and can serve as a base model to other member clinics that may not have various components of integration or operate differently within the continuum of integrated care. The programs by clinics vary. Some of the best practices included in our clinics' integration models include:

- Clinics hiring and training on-site behavioral staff
- Physical proximity of behavioral staff and medical staff
- Referrals from physicians to behavioral staff
- Case conferencing between primary and behavioral staff
- Use of LCSWs, psychiatrists or psychologists as services providers or consultants
- Case management and direct service coordination
- Case conferencing
- Involvement of primary care physicians in behavioral care
- Therapy (limited sessions)
- Group or individual self-management sessions
- Patient Advisory Group
- Collaboration between primary care and behavioral health care staff
- Co-location of primary care and mental health staff at agencies that collaborate
- Collaboration with mental health agencies

There is much more work to be done in order to develop the infrastructure to have integrated programs that meet the needs of patients seeking mental health services. *One of our goals is to develop treatment programs that go beyond a medical model and include a wellness and recovery approach to mental health care services provided.*

**Second, community based primary care clinics have a track record of preventing serious diseases or illnesses, as well as preventing aggravation of illnesses.** While there aspects of a chronic disease model that are not appropriate to addressing mental health issues, there are many components that can be used from the model to address mental health, wellness and even recovery. One of the components is a focus on self-management sessions to teach individuals to help themselves and to encourage empowerment. In addition, using components of a chronic disease model can address persons with co-morbid or co-occurring mental health and health problems.

**Third, programs and funding should focus on places where patients already go to receive care.** Patients should not be required to make an additional trip to somewhere new. Community based primary care clinics are uniquely situated to provide such care to their many patients that are, or could be, experiencing mental health illness and concerns. Our 2004 data shows that over 10,000 patients present with mental health illness as a primary diagnoses. We know that this number is much higher since our data collection does not include secondary diagnoses.

**Fourth, our member clinics serve the priority populations that have been targeted for this funding**. Together our member clinics serve over 160,000 unduplicated patients with nearly 650,000 visits. Ninety-six percent of these patients are under 200% of the federal poverty level and 86 % are people of color (African American, Asian/Pacific Islander, Latino and Native American). Approximately 54% of our patients have a primary language that is not English and half of our patients are uninsured. Thirty-seven percent of our patients are the ages of 0-19, 55% are 20-64 and 8% are 65 and over. The vast majority of our patients are underserved cultural populations, children and youth in stressed families, as well as children/youth at risk for school failure or juvenile justice involvement. In some of our clinics,

many patients are trauma-exposed given the large amount of immigrants that are seen that have suffered in their native countries and continue to suffer trauma here in the States.

**Fifth, providing mental health services in an integrated setting reduces the potential for stigma and discrimination against individuals with mental illness.** Mental health programs that are delivered in a natural community setting, such as community-based clinics, will reduce stigma because of the trust patients have in their community clinics. In addition, our community based health centers are culturally and linguistically competent in providing care to diverse populations which further helps to decrease stigma.

**Finally, our member clinics also focus on supporting families experiencing health problems and concerns.** Our member clinics do focus on supporting families and individuals by utilizing promotora programs, education workshops; and conducting support groups, group sessions and peer support (peer support is particularly critical in school based clinics or teen programs) for individuals and family members experiencing health problems.

## Recommendation

**Conduct screenings and assessments, and increase clinic capacity to conduct screenings, assessments and early interventions.**

Primary care community health centers would like to work in partnership with the county to make the system work better and be more accessible by providing prevention and early interventions that will prevent serious mental illness or prevent the aggravation of mental illness. Conducting screenings and assessments, as well as early interventions in a primary care setting is a proven medical model in preventing aggravated cases of illness. The same approach can be tailored to prevention and early intervention for mental health illness. Such efforts will increase prevention and response to early signs of emotional and behavioral health problems among specific at-risk populations, as well universal and selective target groups. The consistent use of screening and intervention tools in an integrated setting will likely lead to appropriate treatment, wellness and recovery.

The patient population served by our member clinics tends to be more sick than those seen in other systems, have more chronic diseases and illnesses, and have many of the risk factors that are a focus of the PEI funding. There are clear health disparities that are seen in many patients. *One of the goals for screening and assessments would be to start reducing health disparities, including mental health disparities.* Our member clinics have a track record of successfully measuring outcomes. *The other goal is conducting more screening to the universal, specific or at risk populations would be to use data to measure health outcomes in the area of mental health.*

## Other Factors to Consider in funding Community-Based Primary Care Clinics

Whether focusing on directing funds to integrated programs or encouraging more screening and assessments at our community clinics, directing funds to community-based primary clinics will increase capacity for mental health prevention and early intervention programs. We do have a track record of collaborating with other systems and organizations. Programs such as clinics' community outreach/promotora programs, prevention education and of course primary care physicians and behavioral health staff will link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to a primary care setting with mental health services. Finally, our clinics excel in linking individuals and family members to other needed services due to poverty and social factors that impact individual and family wellness, e.g. health insurance programs, WIC, SSI-Medical, Medicare, food stamps, etc.

**REQUIRED ATTACHMENT FOR REPORT TO PLANNING PANEL**

Recommendations developed by Alameda Health Consortium Mental Health Work Group were a foundation for this report. The following clinics had representatives that developed these recommendations:

- Asian Health Services
- Axis Community Health
- La Raza Centro Legal
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- West Oakland Health Council

The recommendations used for community meetings are as follows:

- ***As many of our member CBO primary care clinics focus on integrating mental health services within the primary care setting, PEI program funding targeted to primary care clinics would truly serve to transform the mental health care system.***

- ***PEI funding is intended for programs that prevent the development of serious mental illness and/or provide early interventions that will support individuals and families who are experiencing mental health problems and concerns.***

- ***Community based primary care clinics have a track record in preventing serious diseases and supporting families experiencing health problems and concerns.***

- ***Programs and funding should focus on places where patients already go to receive care – you should not require patients to make an additional trip to somewhere new.***

- ***Community based primary care clinics are uniquely situated to provide such care to its many patients that are or could be experiencing mental health problems and concerns. As such, PEI program funding should be allocated to community based primary care clinics.***

- ***Given the purpose of PEI, we should encourage more screening, and increase clinic capacity to conduct screenings.***

- ***Conducting screenings/early interventions in a primary care setting is a proven model.***

- ***AHC member clinics currently serve about 140,000 patients per year – this would be a large population to screen and provide various prevention and early intervention efforts.***

- ***The vast majority of our patients is underserved and/or has other risk factors that are a focus of PEI programs.***

- ***Our community based health centers are culturally and linguistically competent in providing care to diverse populations.***

- ***Primary care community health centers would like to work in partnership with the county to make the system work better and be more accessible by providing prevention and early intervention screenings and treatment that will prevent serious mental illness.***

# Mental Health Services Act
## Prevention & Early Intervention

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2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable)_Institute On Aging_____
Contact Person____Liam Gibson_____
Address _3330 Geary Blvd, San Francicso, CA 94118-3347_____
_____
Phone No./ Email address 415-7504180x 144/ ___lgibson@ioaging.org_____

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) X Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
X Suicide Risk

Priority Populations

X Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

# COMMUNITY REPORT

**Submitted by the Institute On Aging**
**Center for Elderly Suicide Prevention and Grief Related Services (IOA-CESP)**

## SECTION I - ORGANIZATIONAL BACKGROUND

Established over 30 years ago, the mission of the Institute on Aging (IOA) is to enhance the quality of life for adults as they age by enabling them to maintain their health, well-being and independence. One of the IOA's programs, the Center for Elderly Suicide Prevention and Grief Related Services (CESP), is recognized as a leader in the field of suicide prevention. We respectfully submit the following report to the Panel proposing to expand older adult suicide prevention and early intervention services provided by the IOA-CESP to Alameda County. Focused on older adults, IOA-CESP programs strive to prevent the development of suicide risk factors, to reduce suicide risk factors and suicidal behaviors (ideation, attempts, completions), and to increase factors known to prevent the development of suicide behaviors. The IOA-CESP programs proposed to be expanded to Alameda County include:

(1) 24/7 Crisis Telephone Helpline the *Friendship Line* - for seniors in distress to call for help.
(2) Outreach Calls – low intensity regular calls to seniors to decrease suicide risk factors in older adults.
(3) Suicide Bereavement/Traumatic Loss Support Groups – for individuals who have experienced traumatic loss to suicide or sudden death.
(4) Education to increase professionals' skills in recognizing suicide risk factors and effectively referring clients.

## SECTION II – NEEDS ASSESSMENT, DATA SOURCES, AND BEST PRACTISES

In Alameda County, seniors 65 years and older constitute 11% of the population (U.S. Census Bureau), but between the years 2000-2004, they accounted for 22% of known suicides (California Department of Public Health). According to the National Institute of Mental Health (NIMH), the highest suicide rate of any age group is among those 65 years and older. Depression is the strongest risk factor for late-life suicide and for suicide's precursor, suicidal ideation. Suicide in older adults is a serious yet preventable public health problem (U.S. Department of Heath and Human Services Substance Abuse and Mental Health Service Administration, SAMHSA). With older adults now a fast growing segment of the population, experts anticipated an increase in elder suicides and urge more attention to prevention and early intervention. Older adults are more likely to die as a result of a self-harming act than younger people, because they have less physical reserve, choose more immediately lethal means, and often live alone, reducing the likelihood of being rescued. Suicide risks in older adults are strongly associated with depression, isolation, medical illness, sensory deficits, decline in everyday function, and stressful life events such as bereavement and social isolation (Conwell 2007). Education on how to detect older adults at risk for suicide is necessary on all professional levels. The detection of suicidal thoughts is difficult in older adults, who tend describe physical health issues rather than psychological distress, and are reluctant to disclose suicidal ideation. For example a NIMH study found that 58% of older adults who took their own life had actually seen their primary care provider within a month before death. Grief and traumatic loss groups are recommended by the Suicide Prevention Resource Center (SPRC) for giving mutual support and for helping with the coping process.

The availability of a social support and someone who one can confide in are known to be protective factors for suicide risk in older adults. The most comprehensive study on the effectiveness of telephone help-lines found that telephone help-lines reach seriously suicidal callers, and that suicidality and distress decreases during and after such calls (Kalafat 2007). An 11-year Italian study, about an outreach telephone service support for older adults at risk for social isolation and poor health, noted significantly fewer suicides than would have been expected in a matched population (SAMHSA, De Leon 2002). Strongly supported by the results of this study, experts now recommend outreach telephone support as an effective prevention and early intervention strategy for older adults at risk for suicide (Conwell 2007; *For detailed data sources please see attachment*).

# COMMUNITY REPORT

**Submitted by the Institute On Aging**
**Center for Elderly Suicide Prevention and Grief Related Services (IOA-CESP)**

**SECTION III - RECOMMENDATIONS:**

Currently IOA CESP programs are only marginally used and known in Alameda County. However, community based services as they are offered by IOA-CESP are recommended by experts and are proven to be successful in preventing suicides in older adults. Therefore, we recommend the expansion of the following IOA-CESP programs to Alameda County:

(1) Crisis Telephone Helpline the *Friendship Line.* The CESP program the *Friendship Line* provides reliable, easily accessible 24/7 telephone support for older callers' in a crisis or despair in a non-traditional setting. The *Friendship Line* operates with volunteers and staff, who provide telephone counseling and refer clients to appropriate services. In addition, a unique feature of the *Friendship-Line* is that callers are offered Outreach-Calls for follow-up and support. Volunteers and staff from diverse ethnic backgrounds operate the *Friendship Line* in 4-hour shifts. The program currently offers counseling in Russian, Spanish, and English. For other non-English speaking clients, the program uses the Pacific Bell Telephone Language Bank to interpret. During the last 5 years the *Friendship Line* received an average of only 60 calls per year from callers who disclosed that they lived in Alameda. However, targeted publicity and education would heighten awareness and enable more Alameda County seniors to draw on the *Friendship Line* for crucial support. In addition to promoting awareness of the warning signs of suicidal thoughts and the importance of getting help, the project would need to expand *Friendship Line* staff and volunteers capacities to accommodate the anticipated increase in calls.

(2) Outreach Calls are provided by *Friendship Line* volunteers and staff for clients who suffer from factors known to increase the risk for elder suicide such as depression, isolation, traumatic experiences, and functional loss. Outreach Calls are intended to reduce the impact of these risk factors by providing a sense of connectedness, social support and security, as well as referring clients to other services if needed. For seniors who are not ready yet to accept more comprehensive services, the low-intensity, private character of the Outreach Calls may serve as a first introduction into accepting higher level support services if needed in the future. Similarly, Outreach Calls may prevent or delay the need for more intensive services. Depending on clients needs, Outreach Calls range from daily to weekly 5-10 minutes calls and are provided for a short-term period (about a months) to a longer-term period (a year and longer). Currently, Outreach Calls reach about 150 older adults in San Francisco. Clients are being referred by hospitals discharge planners, case managers, Adult Protective Services, In Home Senior Services, senior centers, friends, and family. In addition, the traditional all-age Suicide Prevention Lifelines refer clients in need for follow-up calls. About 15% of the Outreach Call clients attempted suicide, had suicide plans or expressed thoughts about suicide; 11% had a known diagnosis of clinical depression, and an additional 32% were referred because of depressive symptoms. Currently, Outreach Call clients are on average 78 years old, and most live alone in San Francisco's disadvantaged neighborhoods. Although older African Americans comprise only 8.4% of the San Francisco population, 23% of the outreach-call clients are older African Americans. In addition, Outreach Calls increasingly include older individuals from the LGBT community. Outreach Call services were never promoted in Alameda County. With appropriated publicity and additional funding these Outreach Calls could be expanded to reduce suicide risk factors and built up protective factors against suicidal behaviors in Alamedas County seniors.

(3) Suicide Bereavement/Traumatic Loss Support Groups provide a safe environment in which grieving individuals share their experiences and grief with others in similar situations. Individuals who are experiencing profound grief may also be referred to individual counseling. Eight-week groups are offered by Dr. Patrick Arbore, Director of IOA-CESP, who has over 30 years of experience in grief counseling, suicide prevention and crisis intervention in older adults. Alameda County residents occasionally participate in IOA-CESP grief groups held in San Francisco. However, long travels time is a barrier to consistent attendance. By offering IOA-CESP grief groups in Alameda County, this barrier could be easily overcome and more Alameda County citizens who suffer from grief or traumatic loss could benefit from these groups.

(4) Education is necessary to raise awareness of elder depression and suicide risk, to increase professionals and family members' skills in recognizing depression and suicide ideation among older adults, and to implement a formal process for identifying older adult suicide risks. In previous years, Dr. Arbore, a highly sought after trainer both locally and nationally, spoke about depression in older adults in numerous Alameda County agencies such as the Over 60 Health Center, the California Association of Homes and Services for the Aging, Alameda County Department of Social Services, Crisis Support Services of Alameda County. With increased funding, education sessions (including training of trainers sessions), will be offered focused on suicide screening, prevention and early intervention. In addition, such educational sessions would be an ideal venue to publicize the availability of the *Friendship Line*, the Outreach Calls, and Grief Groups in Alameda County (please see flowchart).

All four of these suggested strategies are in line with the purpose and goals of the prevention and early intervention DMH PEI initiative and address PEI Key Community Mental Health Needs and Priority Populations in many ways:

1. All the recommended programs are targeted to diverse older homebound adults, a group know to have access problems to mental health services because of impaired mobility, suboptimal referrals to mental health services, and under-treatment of mental health problems due to lack of knowledge including, for example, the misconception that depression is a normal part of aging.
2. All the recommended programs are aimed to reduce the psycho-social long term impact of trauma across the lifespan especially in older adults. However, the support groups are open to all ages.
3. All the recommended programs are aimed at reducing suicide and suicide risk and at increasing protective factors against suicidal behaviors. The education initiative especially strengthens the capacity for suicide risk assessment in providers and caregivers across the health and social service spectrum.
4. All programs are targeted to the underserved population of diverse older adults including individuals from the LGBT community, who face many barriers to access the traditional mental health system including being home bound, lack of referral and knowledge, cost, and non-help seeking behavior due to fear of stigmatization.

Outcomes of all above listed programs will be measured as outlined in the MHSA/PEI guidelines and in collaboration with Patricia Arean, PhD, Associate Professor at the University of California, San Francisco, Department of Psychiatry. Valid and reliable measurement tools will be identified and/or created. In addition to process evaluation, we will track impact and outcomes by assessing the following indicators:

A: Individual level for *Friendship Line,* Outreach Calls and Grief Group clients:

- Improved mental health status, especially depression.
- Increase in protective factors including perceived connectedness and social support, as well as appropriate help-seeking activities and acceptance of needed support.
- Decrease in suicidality and suicide risk factors (e.g. depression, social support, and isolation).

B: Program level *Friendship Line,* Outreach Calls, Grief Groups:

- Increased number of older adults in Alameda County who receive early intervention services.
- Increased number of underserved populations in Alameda County who receive early intervention services.
- Increased screening for older adults suicide risk factors and referral to appropriate services.

C: Long-term community:

- Reduced older adult suicide.

# COMMUNITY REPORT

**Submitted by the Institute On Aging**
**Center for Elderly Suicide Prevention and Grief Related Services (IOA-CESP)**

**Attachment**

## Groups and Organizations who Contributed to this Report

1. **Institute On Aging:**

   **Patrick Arbore, PhD,** Director, Center for Elderly Suicide Prevention and Grief Related Services
   **David Werdegar, MD, MPH,** CEO and President
   **Eva M. Schmitt, PhD,** Associate Director Program Evaluations, Research Center

2. **University of California San Francisco**

   **Patricia Arean, PhD**, Associate Professor at the University of California, San Francisco, Department of Psychiatry.

## References


**Conwell, Yeates,** (2007) Suicide in Older Adults: Management and Prevention. Psychiatric Times: http://www.psychiatrictimes.com/Suicidal-Behavior/showArticle.jhtml;jsessionid=JBZC3M0UZ43LEQSNDLRCKHSCJUNN2JVN?articleId=196901880

**De Leo, Diego** et al (2002) Suicide among the elderly: the long-term impact of a telephone support and assessment intervention in northern Italy. British Journal of Psychiatry 181, 226-229.

**Kalafat, John** et al (2007) An Evaluation of Crisis Hotline Outcomes. Suicide and Life-Threatening Behavior 37 (3).

**National Institute of Mental Health** (NIMH) http://www.nimh.nih.gov/

**Suicide Prevention Resource Center** (SPRC) http://www.sprc.org/

**U.S. Census Bureau** http://www.census.gov/

**U.S. Department of Heath and Human Services Substance Abuse and Mental Health Service Administration, SAMHSA**. http://www.samhsa.gov/

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.


Organization* (if applicable)_LifeLong Medical Care
Contact Person Nance Rosencranz
Address PO Box 11247, Berkeley 94712
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**Please attach a list of all groups and organizations that contributed to this report. SEE BELOW*

*What age group does your organization serve or represent? Lifelong serves ALL AGES. This paper focuses on all ages.*

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

Xxx Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

Priority Populations

Xxx Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

# EXECUTIVE SUMMARY:
# INTEGRATED MENTAL HEALTH AND PRIMARY CARE SERVICES

## SECTION I: ORGANIZATIONAL BACKGROUND

LifeLong Medical Care (LMC) is a major provider of comprehensive healthcare services for low-income people in Berkeley and Oakland. We build on 30 years of history in addressing health needs:

- Our 6 community health centers provide primary care, dental care, mental health and social services, podiatry, optometry, and prevention services;
- Our Supportive Housing Program empowers formerly homeless and disabled individuals so that they can develop life skills to maintain a healthy life;
- Our Adult Day Health Center offers a daytime alternative to institutional care for frail and chronically ill adults.

LMC is proud of our participation in many community wide collaborative efforts to increase access to health care for underserved populations. LMC provides high-quality services to underserved people of all ages; creates models of care for the elderly, disabled, mentally ill and homeless; and advocates for continuous improvements in the health of our communities.

In 2007 LMC clinics will provide over 108,000 healthcare visits and serve over 18,000 individuals in communities dramatically impacted by health disparities. 76% of our patients are people of color, 41% are uninsured, 74% have incomes at or below 200% FPL, 17% have a diagnosed mental illness, and 16% are homeless. LifeLong's multidisciplinary staff is culturally, linguistically, and racially diverse, enabling our clinic sites to offer culturally competent care.

## SECTION II: DATA SOURCES

Collaborative care models are more effective than usual care in reducing depression and improving functioning and accessibility to evidence-based care. (Cabassa, 2007; Felker et al., 2004). Treatment in primary care is a cost effective strategy to improve access and reduce mental health disparities among Latinos and other traditionally underserved populations.

Comprehensive service delivery is particularly critical for low-income individuals, especially African-Americans, who not only struggle with the economic and social challenges of living, but also with being significantly more likely to suffer from chronic conditions (Sha, et al, 2005; Silver, et al, 2004; Silverman, et al, 2000 & 1999). Berkeley Public Health found African Americans in Berkeley die earlier and suffer from significantly more chronic disease than do whites (Berkeley Health Status Report, 1999). The lack of mental health care options access/assistance for mentally disabled people results in most low-income and uninsured patients not obtaining care until they become a harm to themselves or others, or are so disabled by their illness that they are unable to provide for their own food, shelter and clothing. (Callahan CM. 2001)

Low-income elderly are more likely to suffer from depression and the least likely to receive treatment: According to epidemiological data, depression affects approximately

10% of older primary care patients (Koenig & Blazer, 1992), and 20% of the low-income elderly (Areán, et al, 2001). Depression alone is associated with increased disability and death in older people (Penninx, et al, 2001). However, even though effective depression treatments exist, very few older adults access these services, and the low-income elderly are least likely to receive treatment (Strothers, et al, 2005).

Ethnic minority patients are less likely to use outpatient specialty mental health services (Neighbors et al. 1992; Takuichi and Uehara, 1996; Miranda and Green 1999). Several studies show that African Americans are less likely to use mental health services than other ethnic groups and only enter the mental health system when they are at their most troubled (Hu, Snowden, Jewell, Nguyen, 1991).

Older African Americans are less likely to desire mental health services because of the stigma attached to mental health treatment (Copper-Patrick, et al., 1997), and are less likely to seek mental health services from their GPs than white elderly, largely because of their fear of mental health treatment (Sussman, Robins & Earl, 1987). Large scale studies of Medicaid and Medicare databases indicate that older African Americans in particular are less likely to receive medication and behavioral treatment for depression (Strothers, et al, 20005; Crystall, et al, 2003), are more likely to suffer side effects from medication treatment (Strickland, et al, 1991), and are less likely to receive a referral to mental health services from their primary care providers than White elderly.

Hispanic Americans experience barriers to obtaining mental health care. (Woodward AM, Dwinell AD, Arons BS, 1992). The Hispanic American population faces barriers to access to both medical health and mental health care. The financial barrier is a major determinant of mental health service access. Cultural and language barriers, insufficient numbers of Hispanic manpower in the healthcare professions, high numbers of uninsured Hispanics and discrimination also interfere with Hispanic access to mental health care (Ruiz P, 2002)

Maternal Depression has a negative impact on women and the development of their children, putting the families At-Risk. As a result, researchers argue that postpartum depression may impact a child's life by causing delays in language development, negatively impacting their ability to develop emotional bonds with others, and increasing the risk of distress from neglect (U.S. Department of Health and Human Services, womenshealth/gov. "Depression During and After Pregnancy").

## SECTION III: RECOMMENDATIONS

***We recommend that PEI funding focus on primary care/mental health integration, using a variety of strategies appropriate for various ages and cultural groups, a few of which are described below.***

LifeLong is a leader and innovator among the community clinics in the effort to integrate primary care and mental health services to serve ethnic minority populations. We know that many of our patients have undiagnosed mental health conditions and that our clients are often reluctant to enter the mental health system because of the stigma and the difficulty in gaining access to care (especially for the uninsured). In response, and consistent with our commitment to eliminate disparities in health access and health status, we have implemented several programs. Our goal is to improve screening, education and

treatment of mental health conditions within our primary care setting. All LifeLong programs strive to be culturally accessible to patients of all ages.

- **IMPACT**[1], is an evidence-based early intervention which includes all components of Wagner's Chronic Care Model. IMPACT screens all adult primary care clinic patients annually for depression and provides a short term, patient driven, team based intervention with referral to specialty care if improvement goals are not achieved. The screening process is integrated into the primary care visit and primary care providers work closely with a depression care manager. This program is particularly targeted to identifying individuals who have early stage depression or depression that is masked by physical symptoms and has gone undetected. Treatment is generally completed within 4 – 6 months. LifeLong implemented IMPACT at our Over 60 Health Center and Downtown Oakland Clinic in 2006-7 and will implement at all sites in 2008.

- The **CenteringPregnancy/Centering Parenting® Program** alters routine prenatal care by bringing women out of exam rooms and into groups for their care. Women are invited to join with 8-12 other women/couples/teens with similar due dates in meeting together regularly during their pregnancy. Groups continue through the infant's first year, meeting every month for the first four months and then bi-monthly. Centering emphasizes early identification and treatment of maternal depression, development of strong parent/infant bonds, and family education on child development. Groups are offered for both Spanish and English speaking families, and materials and methods are tailored to meet the needs of a culturally diverse patient population. Centering:

    - Increases access to services for high risk populations
    - Is strength based – relying on the wisdom of the group
    - Promotes well being that allows new moms to be effective parents.

- **Integrated Social Services Teams** serve residents at subsidized housing sites, through coordinated mental health and primary care. These teams are models for increasing the primary care provider's ability to identify and treat mental health conditions. Clients are primarily African American adults who have been victims of childhood and adult trauma.
- **The Rosa Parks Collaborative** links mental health services provided at an elementary school serving high risk families with primary care at LMC. Mental health services are offered in a trusted and easily accessible school setting.

These LMC programs exemplify the tremendous positive impact that integrated primary care and mental health services can have in underserved communities. The attachment offers additional information.

[1] Improving Mood – Increasing Access to Collaborative Treatment

## ADDITIONAL INFORMATION ABOUT THE IMPACT PROJECT[2]

As more emphasis is placed on the connections between mental and physical health, the IMPACT model offers a model of depression care that relies on a strong integration between primary care and mental health services; not simply co-locating the two. LifeLong Medical Care's Over 60 Health Center has been piloting implementation of the IMPACT model for the past 18 months and strongly recommends its use as a means of reducing stigma, discrimination and disparities in access to mental health services for adults. This model is well suited to meeting the MHSA goal of early intervention in our community health center population.

IMPACT includes all the components of quality care that are detailed in the Chronic Care Model[3], including Community resources and policies, Health system organization, Self management support, Delivery system design, Decision support and Clinical information systems. The IMPACT toolkit has been extensively studied and has demonstrated effectiveness for managing depression in the general adult population, older adults, and with minority consumers. At LifeLong, approximately 19% of patients have a diagnosis of depression or other mental illness. In the older adult population, and particularly among low income elders, suffering in silence is common; many are hesitant to seek care due to their own misconceptions about the disease or shame in disclosing it.

In IMPACT Care, a depression care manager (DCM, who may be a nurse, psychologist, or social worker) with consultation from a psychiatrist, helps consumers/patients and their regular doctors treat depression in the primary care setting. The DCM helps educate patients about depression, closely tracks depression symptoms and side effects, helps make changes in treatment when needed, supports patients on antidepressants, and offers a brief course of psychotherapy to help patients make changes in their lives. A Consumer Review Team composed of primary care provider(s), DCM(s) and consulting mental health professional meets weekly to review current cases and identify where changes in intervention should be considered. An information system prompts the Team members to consider treatment guidelines, identifies opportunities for intervention (recalls/reminders) and provides summary information to help evaluate program successes and opportunities for improvement.

Prior to implementing this model of care, the clinics at LifeLong lacked a standard protocol for screening patients for possible depression and for consistent follow up in those who desired to start treatment. Also lacking was an evidence-based approach to provide proactive therapeutic interventions, the technology to track progress and the collaboration to support patient self-management. Using this model has allowed us to further integrate the medical and mental health care. All patients are screened annually. A Consumer Review Team meets regularly to coordinate care and plan visits with patients so that progress can be closely tracked and their successes supported. A monthly maintenance group offered to those who are no longer in need of active treatment offers an opportunity to monitor symptoms and receive support in a group setting.

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[2] See also http://impact-uw.org/files/IMPACTwebslides.pdf

[3] http://www.improvingchroniccare.org/change/index.html

More than 1,500 patients have been screened over the past year with approximately 20% screening positive for possible depression. Coordination of care has improved and wait times between referral and treatment have declined substantially. Clearly the model works and offering it within the primary care setting where older adults are most likely to access it enhances their care and their outcomes.

A Patient Advisory Group meets monthly to provide input on the implementation of IMPACT services. By welcoming and incorporating the feedback the Group into the health center, staff is educated by their patients and patients are empowered to participate in their care. Feedback can come in the form of patient input regarding engaging patients in this new service, establishing groups as well as critique of patient education materials used to describe our services. The Group's input provides further explanation of the stigma attached to the use of mental health services by today's elders and helps to draw out creative solutions to treatment barriers for depression and other mental health issues.

Individual Outcomes include improved quality of life and increased ability and self empowerment to address other chronic conditions, e.g. diabetes.

## ADDITIONAL INFORMATION: CENTERING PREGNANCY AND PARENTING

CenteringPregnancy® and Centering Parenting®[4] are models of health care delivery that integrate the provision of health assessment, education, and support within a stable group of women, families/ friends, and babies. The results of the first randomized control study of the Centering model, "Group Prenatal Care and Perinatal Outcomes: A Randomized Controlled Trial" was published in the August 2007 issue of Obstetrics and Gynecology. The authors concluded that the women randomized to CenteringPregnancy® care had clinical and psychological advantages to those receiving individual care. The study documented a 33% reduction in the odds of preterm birth. Women in group reported greater satisfaction with their care, had more prenatal care knowledge, felt more prepared for labor and delivery, and were more likely to initiate breastfeeding – all factors directly linked to well being and promotion of mental health for themselves and their children. The model is an evidenced-based model of group care within a trusted primary care setting.

The **Centering® Program** has three care components:

### Assessment

Women enter a group after their initial prenatal nursing/medical evaluation. At each session the standard prenatal assessment is completed within the group setting. Unless a woman develops medical problems she would not have to re-enter an exam room until 38-40 weeks gestation. Women participate actively by checking and recording their

[4] See also http://www.centeringpregnancy.com/. The Centering parent organization is changing the organization's name to Centering Healthcare Institute, Inc. in early 2008.

own weight and blood pressure. With a practitioner, each woman has individual time to share problems and concerns and to evaluate the health status of the baby.

## Education

A general curriculum is defined with handouts, worksheets, and suggested visual aids. All of the handouts are available in both English and Spanish. Topic areas include:

| | | |
|---|---|---|
| nutrition | pregnancy problems | communication |
| exercise/relaxation, | infant care and feeding | comfort measures |
| childbirth preparation, | postpartum issues | Sexuality |
| abuse issues | parenting | self-esteem |

The education process occurs though a discussion format.

## Support

A stable group allows for building of trust among the members. The Centering Pregnancy Program begins early in pregnancy and continues as Centering Parenting through the infant's first 15 months. Women /couples become invested in each other and build community as a result of their interactions. This leads to increased support and decreased feelings of isolation. Time for refreshments and socialization during the sessions helps to promote cohesion

Parents tell us they share info from groups with friends and family. The interactive nature of group care has increased parents' confidence and abilities in taking their infant's temperature, knowing when to call doctor, what's normal to expect and what is not. The groups are also a great environment for parents to discuss what helps infant development, hear ideas from each other, and observe a cohort of infants demonstrating different growth and development levels. New parents build parenting skills and confidence in their group. From the perspective of parents, perhaps the strongest impact is the development of a community of new parents who form long term bonds which continue even after the groups have ended. This new network transcends child care issues and becomes a critical support system during a high risk period (pregnancy and new parenthood) for high risk families (low income families of color).

In all groups we conduct a regular screening with the Edinburgh Postnatal Depression Scale: women are referred to individual counseling or a drop-in group for post partum depression that has developed in response to the high rate of post partum depression. A psychiatrist is available on site for specialty care consults and referral.

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

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2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable): Pool of Consumer Champions; PEERS; Alameda County Network of Mental Health Clients
Contact Person: Sally Zinman, Consumer relations Specialist, Office of Consumer Relations, ACBHCS
Address: 2000 Embarcadero Cove, Suite 400, Oakland CA 94606
Phone No./ Email address: 510-639-1335 or 510-644-1916/ szinman@acbhcs.org or szinman@aol.com

**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) X Adults (18-59) ❒ Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

❒ Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
X Stigma and Discrimination
❒ Suicide Risk

Priority Populations

*Note: Stigma and Discrimination affect all populations*

X Underserved Cultural Populations
X Individuals Experiencing Onset of Serious Psychiatric Illness
X Children/Youth in Stressed Families
X Trauma-Exposed
X Children/Youth at Risk for School Failure
X Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

Executive Summary

# Priority of Discrimination and Stigma Reduction

**Organizational Background:** This Executive Summary represents the consensus recommendations of three (3) consumer operated groups/organizations:

Th**e Pool of Consumer Champions (POCC)** made up of 140 plus clients throughout Alameda County. The majority age group represented is 26 -55, 78%. 73% identify as non-Caucasian, with the largest represented ethnicity being African American, 42%.
**PEERS,** Peers Envisioning and Engaging in Recovery Services, is a consumer-run agency that offers WRAP and other recovery oriented trainings throughout Alameda County, conducts outreach and education, and brings consumers throughout Alameda County to the table to participate in policy and program development.
**Alameda County Network of Mental Health Clients** (ACNMHC) is the administrative consumer-run umbrella for five (5) consumer run programs serving clients throughout Alameda County. These programs include two drop-in advocacy centers, a housing support program, a hospital and other institutional setting visitation program, and a consumer employment and training program.

**Data Sources for the Prioritization of Stigma and Discrimination Reduction:**
The California Network of Mental Health Clients (CNMHC) in its initial position paper on the Implementation of the Mental Health Services Act recommended that "the Department of Mental Health identify a minimum percentage of funds from Prevention and Early Intervention Program Revenue that will be spent on Campaigns to Address Discrimination and Stigma. **Ranking the elimination of discrimination and stigma among the highest priorities of the consumer community, "the CNMHC recommends 20% of the Prevention and Early Intervention Program allocation for this effort."**[1]

The Mental Health Services Act (MHSA) itself prioritizes Discrimination and Stigma reduction within PEI. Following is the MHSA's mandate of PEI components:
(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.
(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
(4) Reduction in discrimination against people with mental illness.

**Of the four (4) components mandated by the MHSA, two relate to discrimination and stigma.**

Consumers also have indicated, throughout the years, the high price that discrimination and stigma exacts on their lives and thus the importance of reducing them.

In 1987 a groundbreaking research project developed and conducted by consumers, The Well Being Project: Mental Health Clients Speak for Themselves, surveyed over 500 mental health clients, family members , and mental health professionals and caregivers. The survey found that "more than half of the clients interviewed felt that they had been discriminated against because of psychiatric labeling." [2] In 1998, the California Network of Mental Health Clients (CNMHC) did focus groups throughout California to determine how mental health clients define "client culture." Clients self identified as being victims of discrimination and stereotyping more than any other client culture characteristic. In fact, the experience of discrimination was the most repeated characteristic of client culture. [3]

In 2007 clients - again - conveyed the devastating effects stigma and discrimination have on their lives. In filling out a Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey (reference) at the "Breaking the Ties that Bind: Challenging Stigma and Discrimination" Conference, they proposed what the anti-discrimination and stigma message should be. In these anti-discrimination and stigma messages, they described the effects of discrimination and stigma on their lives. They emphasized the inequality they experience, in value, in access, and in relationships. They also highlighted the barriers to recovery and hope, caring and empathy, and social inclusion that discrimination and stigma generate.

The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America states that "Stigma is a pervasive barrier to understanding the gravity of mental illnesses and the importance of mental health." [4] Clients have been saying this for many years. This is the time and the PEI the source of support to prioritize a Stigma and Discrimination Reduction Campaign in Alameda County.

**Recommendations:**

The POCC, PEERS, and the ACNMHC recommend that the reduction of discrimination and stigma should be among the highest priorities within Alameda County's Prevention and Early Intervention (PEI) program, receiving a minimum of 10 % of the funding. Furthermore, the POCC, PEERS, and ACNMHC propose that Alameda County support a consumer operated discrimination and stigma reduction program in partnership with County administration, providers, and family members as a priority for PEI funding.

Alameda County has seen the growth of a critical mass of consumer advocates with the Pool of Consumer Champions. Also, both PEERS and ACNMHC have grown in capacity, consumer leadership, and skills and capability throughout the years. Alameda County consumers are ready and able to take on the leadership of the County's discrimination and stigma reduction program. Moreover, consumer leadership of Alameda County's stigma and discrimination program will of itself be a strong anti-discrimination and stigma message. It is a message from consumers that they are (and feel) competent and capable to take on such a large endeavor. It is also a message from the County administration and mental health community that they trust that consumers can lead such a large project. A consumer led anti- discrimination and stigma program, by the very fact that consumers are doing it and that the County and mental health stakeholders support it, will model the message and chip away at discrimination and stigma.

**Program Priorities and Strategies**

The priorities and strategies of the consumer led discrimination and stigma reduction program will be guided by Alameda County consumers, in collaboration with providers and family members. The first step to assess the depth of the problem and solutions was to conduct a Survey, "Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey", which was distributed at the "Breaking the Ties that Bind: Challenging Stigma and Discrimination" Conference as well as at other meetings, and through a mailing. Our second step will be to do a literature search of promising practices regarding the reduction of stigma and discrimination.

Of the initial 120 responses of this Survey, consumers, providers, and family members, all groups, overwhelmingly identified "a multi-faceted consumer operated program targeting employer, housing, schools, criminal justice/police, media, faith based agencies, and healthcare professionals" as the kind of stigma and discrimination reduction program they would most like to see in Alameda County. Consumers also ranked enhancing personal skills, abilities, and self esteem; addressing external discrimination; clarifying the consumer anti-discrimination and stigma message; and focusing on and inclusion of multi-cultural populations and perspectives as important ingredients of a discrimination and stigma reduction program.

A question of the Survey asked respondents to identify what groups discriminate and stigmatize against people with mental disabilities the most. All respondents, consumers, providers and family members, ranked the criminal justice system, including police, judges and attorneys as the group that most discriminates and stigmatizes followed by community members and society in general. Other groups that consumers ranked among the top five (5) in practicing discrimination and stigma against people with mental disabilities were the media, family members, and the mental health system itself.

Another question asked what kind of attitudes did the group who discriminated or stigmatized exhibit. All three groups ranked Judgmental as the most prevalent attitude exhibited, with Disrespect and Fear ranking among the top five most prevalent discriminating attitudes by all three (3) groups.

In developing the consumer-led discrimination and stigma reduction program, all of this feedback, including more from an on going process of eliciting feedback including community meetings, will be considered and incorporated into the program priorities and strategies, in relation to target groups, attitudes, and programs. As the Program is developing we will provide the Planning Panels and the Ongoing Planning Council with updated Reports.

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[1] Position Paper on the Implementation of the Mental Health Services Act, California Network of Mental Health Clients, September 2004, p. 10. http://www.californiaclients.org/pdf/CNMHCImplementationOfTheMHSA.pdf

[2] People Say I'm Crazy, The Well Being Project, Jean Campbell and Ron Schraiber co directors, The California Network of Mental Health Clients under contract to The California Department of Mental health, Office of Prevention, 1989, p.57.

[3] Client Culture Training/Focus Groups Project Report, a project of the California Network of Mental health Clients, funded by the California Department of Mental Health, 1998, Executive Summary, pp. 1 -5.

[4] The President's New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America, Final Report, July 2003. p.20.

**List of Groups and Organizations that Contributed to the Report**


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**Report from Stigma and Discrimination Reduction Survey:**
**Social Inclusion (Discrimination and Stigma Reduction) Survey**

Surveys Received

This Report is based on 120 returned surveys, not all of them filled out so that data could be collected. A plurality of these surveys were filled out and returned at the October 19 Conference, "Breaking the Ties that Bind: Challenging Stigma and Discrimination." Surveys were distributed to and filled out by consumers only after this Conference. The breakdown of self-identification of persons who filled out the survey follow:
Consumers: 66
Family Members: 22
Providers: 32

Some persons self identified in several ways and have been counted in all the categories with which they identified.

Demographics

**Consumers.**
56 Consumers responded to the ethnicity question. The breakdown follows:
African American: 36 %
Caucasian: 30 %
Asian: 9 %
Latino: 16 %
American Indian: 3 %
Multi-ethnic: 3 %
Middle Eastern: 1 %

People other than Caucasian represented 68 % of the Consumer respondents.

**Providers**

32 Providers responded to the ethnicity question. The breakdown follows;
Caucasian: 47 %
African American: 22%
Asian: 15%
Latino: 12%
Multi-ethnic: 3%
American Indian:
Middle Eastern:

People other than Caucasian represented 52 % of Provider respondents.

**Family Members**

| | |
|---|---|
| African American | 45% |
| Caucasian | 41% |
| Latino | 9% |
| Multi-Ethnic | 5% |

People other than Caucasian represented 59% of Family respondents.

General Observation: Providers who responded to the Survey were less representative of diversity than consumers and family members, and the only group for which Caucasians were the largest single ethnicity.

**Results of Surveys**

Question 1: What groups stigmatize and discriminate against people with mental disabilities:

Consumer Reponse:

1. Criminal Justice System, including police, judges, attorneys 118
2. Community Members and society 89
3. Media 67
4. Family Members 56
5. Mental health system administration, professionals, and providers 55

Provider Response:

1. Criminal Justice System, including police, judges, attorneys 62
2. Community Members and society 57
3. Media 44
4. Mental health system administration, professionals, and providers 30
5. Employers 26

Family Members Response:

1. Criminal Justice System, including police, judges, attorneys 44
2. Community Members and society 31
3. Employers 25
4. Landlords/housing personnel 19
5. Mental health system administration, professionals, and providers 17

Observations:

All three (3) groups ranked the criminal justice system and community members and society as the first and second groups of people that most exhibit stigma and discrimination.

Consumers and family members identified the criminal justice system as the most discriminating in significant numbers, while providers identified community members and society almost as much as the criminal justice system as the most discriminating.

Providers ranked the mental health system as more discriminating than consumers and family members did.

Consumers alone ranked family members among the most discriminating groups. Family members ranked employers and landlords higher than consumers and providers. This, along with family members ranking of the mental health system within the top five (5), provides an insight into the barriers family members experience in assisting their relatives in accessing jobs, housing, and the mental health system.

Question 2: What kind of attitudes did the group who discriminated or stigmatized exhibit?

Consumers response:

1. Judgmental 99
2. Abuse 73
3. Disrespect 69
4. Controlling 68
5. Fear 51

Providers response:

1. Judgmental 61
2. Disrespect 39
3. Fear 32
4. Ridicule 25
5. Shunning 24

Family Members response:

1. Judgmental 31
2. Controlling 25
3. Abuse 18
3 Fear 18
4. Disrespect 17

Observations:

All three groups ranked Judgmental as the most prevalent attitude exhibited. by groups that stigmatize and discriminate. Disrespect and Fear are also ranked among the five (5) most prevalent discriminating attitudes by all three (3) groups. Both Consumers and Family Members ranked the same five (5) attitudes, although in different order. Providers ranked Abuse as the lowest of any attitude, while consumers and family members ranked it among the top three (3) discriminating attitudes.

Question 3: What kind of Social Inclusion or Stigma and Discrimination Program would you like to see Alameda County fund?

Consumers Response:

1. A multi-faceted consumer operated program targeting employers, housing, schools, criminal justice/police, media, faith based agencies, and health care professionals 130
2. Enhance personal skills, abilities, and self esteem, such as WRAP programs, job mentorship, and promoting independent living skills 85
3. Address external discrimination, such as legal and civil rights, discrimination in housing, employment, and schools, and an effective complaint system 80
4. Clarify the consumer ant-discrimination and stigma message 44
5. Focus on and inclusion of multi-cultural populations and perspectives 41

Provider Response:

1. A multi-faceted consumer operated program targeting employers, housing, schools, criminal justice/police, media, faith based agencies, and health care professionals 80
2. Enhance personal skills, abilities, and self esteem, such as WRAP programs, job mentorship, and promoting independent living skills 53
3. Address external discrimination, such as legal and civil rights, discrimination in housing, employment, and schools, and an effective complaint system 43
4. Media campaign, including TV and radio initiatives 31
5. Target mental health and substance abuse providers and systems 22

Family Members response:

1. A multi-faceted consumer operated program targeting employers, housing, schools, criminal justice/police, media, faith based agencies, and health care professionals 54
2. Enhance personal skills, abilities, and self esteem, such as WRAP programs, job mentorship, and promoting independent living skills 26
3. Target mental health and substance abuse providers and systems 2 4
4. Address external discrimination, such as legal and civil rights, discrimination in housing, employment, and schools, and an effective complaint system 21
5. Focus on and inclusion of multi-cultural populations and perspectives 12

Observations

All groups, consumers, providers, and family members, ranked a multi faceted consumer operated program, enhance personal skills, and address external discrimination among their top five (5) Stigma and Discrimination programs, although not in the same order. A multi faceted consumer operated program was the highest preference of all three (3) groups.

Interestingly, providers and family members, not consumers, ranked target mental health and substance abuse providers and systems as among their top five (5).

Clarifying the stigma and discrimination message was important to consumers only, possibly suggesting that consumers want to determine the anti-stigma and discrimination message as well as their dissatisfaction with prevailing anti-stigma and discrimination messages. Targeting the mental health system was more important to family members than the other groups, possibly indicating their frustration in getting good services for their relatives and in alignment with their ranking of landlords, employers, and the mental health system among the top five (5) groups that stigmatize and discriminate against mental health consumers.

12/12/2007

**Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey (Continued)**
**Responses to Open Ended Question:**
**What Do You Think the Anti-Discrimination and Stigma Message Should Be?**

**Demographics of Consumer Respondents**

Of the 66 Consumers that responded to the survey, 56 responded to the ethnicity question. The breakdown follows:
African American: 36 %
Caucasian: 30 %
Asian: 9 %
Latino: 16 %
American Indian: 3 %
Multi-ethnic: 3 %
Middle Eastern: 1 %

People other than Caucasian represented 68 % of the Consumer respondents.

**Responses**

The categories of this report under which the responses are organized were arbitrarily created based on similarities observed in different "messages."

Sometimes different messages were embedded in the same comment. In these cases, the different messages in the same comment were represented in different categories.

The category of equality – in value, legal, access too services, and in relationships - was recommended as the anti-discrimination and stigma message 17 times.

The category of care and compassion was presented as the anti-discrimination and stigma message 10 times.

The category of recovery and hope was recommended as the anti-discrimination and stigma message 8 times. The category of social inclusion was also stated as the anti-stigma and discrimination message 8 times.

Other categories of "messages" were suggested 5 or less times. These included:
Respect: 5 times
Inclusion in Decision Making and Mental Illness is like Other Physical Illnesses were each proposed 4 times each.
Spirituality and No Labels were proposed as the anti-stigma and discrimination message 3 times each.
Other categories that were mentioned 2 or less times were: There is no such thing as normality; reducing stigma and discrimination will result in people accessing treatment;

mental health clients are not violent; and mental health clients are as capable as anyone else.

Relationship to Popular Anti- Stigma and Discrimination Messages

Noticeable in that it is only mentioned once is the commonly accepted anti-stigma and discrimination message that stigma is a barrier to accessing services. Only one consumer presented this as an important aspect of reducing stigma and discrimination. This suggests that some consumer advocates are accurately representing their constituency when they say that stigma and discrimination is more problematic because it is a barrier to life, rather than a barrier to treatment.

In addition, the commonly repeated anti-stigma and discrimination message that mental illness is like other chronic diseases was only represented 4 times in these survey responses.

12/12/2007

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.

Organization* (if applicable) Safety Net Collaborative
Contact Person Nancy S. Halloran
Address 614 Grand Ave., #400, Oakland, CA 94610
Phone No./ Email address 510-847-3833, nshalloran@sonic.net

***Please attach a list of all groups and organizations that contributed to this report.***

***What age group does your organization serve or represent?***

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) **X** Adults (18-59) **X** Older Adults (60+)

***Under each category, choose the item your report PRIMARILY addresses:***

Key Community Mental Health Needs

**X** Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
**X** Stigma and Discrimination
❒ Suicide Risk

Priority Populations

**X** Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

**For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp**

## SECTION I - ORGANIZATIONAL BACKGROUND

This executive summary and the attached brief reports are submitted on behalf of the Safety Net Collaborative (SNC). The SNC is a cooperative project of Alameda County's major healthcare institutions that serve the un- and underinsured people of the county:

- Alameda Health Consortium / Community Health Center Network,
- Alameda County Medical Center, and
- Alameda County Public Health Department.

The focus of the SNC is improvement to the system of chronic disease care, in particular among the county's low-income and minority people. The group began meeting in 2000, and has steadily improved the capacity of the system to support patients' ability to manage their chronic disease and take charge of their own health. In November 2007, the executive leadership of the partner institutions endorsed a system-wide Chronic Care Improvement Plan focused on diabetes. One of the five domains targeted for improvement is addressing the need for behavioral health services for people with chronic disease.

## SECTION II - DATA SOURCES:

**Attachments:**

- Mental Health America (formerly National Mental Health Association) Position Statement on Integration of Mental and General Health Care
- List of References

**Other Sources:**

- Family Care Network Substance Abuse and Mental Health Capacity Development Project (report not yet available).

## SECTION III - RECOMMENDATIONS:

The Safety Net Collaborative recommends that some of the new resources made available through the Mental Health Services Act be used to **provide stable, on-going support to integrated behavioral care in Alameda County's safety net primary care clinics.**

The MHSA PEI program could help the county move toward integrated care in a number of ways:

- By supporting the salaries of mental health professionals who are co-located in medical clinics and become part of the care team. These staff positions could be part of the clinic's own staff, or could be provided by a collaborating agency.
- By providing on-going training and consultation to primary care providers to build skills in screening and brief interventions that have been validated to be effective.
- By sponsoring, collaborating with and funding the state-of-the-art behavioral health integration projects that already exist or are emerging at numerous sites around the county.

**PEI Purpose.** The SNC recommendation supports the purpose of the Prevention and Early Intervention Program, to "engage persons prior to the development of serious mental illness or serious emotional disturbances, or…to alleviate the need for additional mental health treatment and/or to transition to extended mental health treatment." Providing behavioral health resources at primary care clinics will enable PEI funding "to be used to prevent mental health problems or to intervene early with relatively short duration and low intensity approaches to achieve intended outcomes" as stated in the PEI guidelines.

It also follows the directive of the guidelines to leverage additional existing resources. By using a dissemination model, it allows for the use of specialist mental health teachers to impact a significant number of primary care providers while those providers work within the general medicine setting. It improves the limited psychiatric knowledge base that the typical internal medicine physician usually has. It allows patients, who otherwise would find it stigmatizing or logistically difficult to go to a specialized mental health center, to obtain behavioral health care in a familiar general medical setting.

**Key community mental health needs, priority populations.** Integrating mental health services with primary care services is a means for addressing all of the listed needs, but is especially significant for addressing 'Disparities in Access to Mental Health Services' and 'Stigma and Discrimination.' 'Underserved Cultural Populations' are particularly likely to benefit from location of behavioral health in familiar community health locations, where they do not have to make a separate trip to receive services that are unfamiliar to them, and which are often viewed as alien.

People with chronic disease often have long-term trusting relationships with their providers. They are more likely to have repeated contacts with the healthcare system, due to their physical illness. These trusting relationships could form the foundation for successful prevention and early treatment of mental illness, but only if the medical providers are trained to recognize the warning signs, and the behavioral care resources are available

According to Kirk Strosahl, 80-90% of most common complaints in primary care settings have no organic cause; 67% of psychoactive agents and 80% of antidepressants are prescribed by PCP. In 2004, California's community health clinics provided over 805,282 mental health visits annually. Of these, over 550,000 were visits to primary care physicians (*OSHPD Annual Utilization Report of Primary Care Clinics 2004)*. This represents approximately 14% of all mental health visits among Californian's under 200% FPL.[1]

Nearly half of all individuals with a diagnosable mental health disorder do not seek traditional mental health care (*Strosahl, 2001*). Primary care providers deliver almost half of all mental health care in the United States (*Beardsley et al., 1988*). Referral options exercised by a primary care physician have a tendency not to work due to patients' reluctance to follow through with the next visit (*Strosahl, 2001*).[2]

Integration of services takes time and resources dedicated to coordination, but increasingly best practices research is indicating that it is essential. This is why both the Mental Health America and the Health Resources and Services Administration have adopted integration of behavioral health care services into primary care sites as a goal. HRSA is requiring all new FQHC grantees to "include plans for increased mental health and substance abuse services. Our ultimate goal is a system of seamless, comprehensive care –where mental

health, behavioral health and substance abuse services are linked appropriately in the primary care setting –where the mental health provider is a key member of the entire health care team."[3]

**Potential desired outcomes** that would be associated with integrating PEI with primary care programs include, in particular:

**Individual & Family Outcomes:**

*Prevention*

- Increased knowledge of social, emotional, and behavioral issues
- Increased knowledge of risk and resilience/protective factors

*Early Intervention*

- Enhanced resilience and protective factors
- Reduced (controllable) risk factors
- Improved mental health status
- Increased appropriate help-seeking

**Long-Term Community**

- Enhanced wellness and resilience
- Reduced stigma
- Earlier access to MH services

**Program/System**

*Changes in non MH partner organizations:*

- Increase in number of organizations with a formal process for identifying individuals/families with social, emotional, and behavioral issues
- Enhanced capacity of organizations to provide prevention programs and EI services
- Increase in number of prevention programs and EI activities
- Increase in number of organizations providing prevention programs and EI programs

*Results*

- Increase in number of individuals and families identified as needing prevention programs and EI services
- Increase in number of individuals/families who receive prevention programs and EI services
- Increase in the number of individuals/families from underserved populations who receive prevention programs and EI services

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[1] Cited in Paine, J. "Integrated Behavioral Health Integrated Behavioral Health and Primary Care," MHSOAC Prevention & Early Intervention In-Service Training, August 2006. http://www.dmh.cahwnet.gov/MHSOAC/docs/J.PaineIBHandPC-3-12..pdf, accessed 12/14/2007.

[2] Cited in La Clinica de la Raza, "The Behavioral Health Integration Project," October 25, 2006. Unpublished.

[3] Steve Smith, Remarks to the HRSA-SAMHSA Primary and Behavioral Health Care Summit. December 2004. Cited in Paine, J.

# Position Statement 13: Integration of Mental and General Health Care

## Policy

Mental Health America is committed to the principle that mental health is an essential part of every person's health and well-being and that every child, adult, and family should receive mental health and substance use prevention, early identification, treatment, and long-term support regardless of how they enter the healthcare system.

Mental Health America believes that treating the whole person through the integration of mental and general health care will save lives, reduce negative health outcomes, facilitate quality care, and result in long-term cost savings.

Mental Health America believes that for people who live with chronic mental illnesses, general health is especially important, as a healthy body contributes to mental health recovery. Mental Health America believes that integrated healthcare systems enhance the essential role that social support services play in the recovery process.

Mental Health America believes that integration must involve the entire medical community and include the full continuum of mental health care services. Providers on both sides of the mental and general health care interface should receive full and timely information and should follow evidence-based protocols in order to identify and treat the whole person.

## Background

The Institute of Medicine (IOM) defines mental health integration (MHI) as a comprehensive approach to promoting the health of individuals, families and communities based on communication and coordination of evidence-based primary care and mental health services. It emphasizes integration as an example of quality health care delivery design that facilitates communication and coordination based on consumer and family preferences and sound economics.

The Institute of Medicine's report on Improving the Quality of Healthcare for Mental and Substance-Use Conditions[1] characterizes integration or collaborative care as:

- Communication exists when each clinician caring for the patient (consumer) shares needed clinical information about the patient (consumer) to other clinicians also treating the patient (consumer)
- Collaboration is multidimensional, requiring: a shared understanding of goals and roles, effective communication, and shared decision-making.
- Care Coordination is the outcome of effective collaboration and corresponds to clinical integration.
- Clinical integration is the extent to which patient (consumer) care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients (consumers).

The interface of mental and general healthcare is well documented. There is a growing awareness of the influence of mental health and substance use conditions and the burden they place on individuals, overall health, and to society. Mental health and substance use conditions are widespread among persons with other health conditions including cancer, heart disease, diabetes, and other illnesses. Depression can adversely affect the management of chronic illnesses such as cardiovascular disease and diabetes[2]. The Centers for Disease Control and Prevention (CDC) have pointed to the influence of mental health conditions on the onset, progression, and outcome of other illnesses[3]. The CDC also points to the correlation between mental health conditions and health risk behaviors such as physical activity and tobacco use. There is also a growing body of research demonstrating the alarmingly high rates of overall health problems and premature death among individuals with serious mental illnesses[4]. In fact, people with mental health conditions current die 25 years earlier than other Americans[5].

Integration has proven to demonstrate improved health status in consumers and improved ability of physicians to manage mental health conditions[6]. According to Mental Health, United States, 2004, a growing number of studies demonstrate that programs such as the chronic care model are effective and cost-efficient for improving the treatment of depression in primary care and that there are promising signs that the model is applicable to other mental health conditions. "Collaborative care has been shown to be predictably efficacious and effective if the type of relationship between mental health and medical providers, the population served and the type of service provided are adequately specified[7]."

The current health care system is unable to adequately address both sides of the primary care/behavioral health interface. Although primary care provides the majority of mental health care, barriers such as lack of financial compensation and available time with consumers make it difficult for health care systems to implement effective treatment strategies. Unfortunately, primary care providers commonly fail to recognize or treat some disorders including substance use disorders. Physicians may lack the knowledge or the time to adequately diagnose and treat mental health conditions. Mental health providers suffer some of the same problems with a lack of knowledge of or time to diagnose physical health conditions.

The primary responsibility for providing mental health care continues to fall on primary care. In fact, 54% of individuals with a mental health condition are served in primary care settings. According to the American Academy of Family Physicians, 42% of patients with clinical depression and 47% with generalized anxiety disorder (GA) were first diagnosed by a primary care physician [8]. It is also important to note that most individuals prefer to receive their mental health care within primary care since it is perceived as less stigmatizing than the traditional mental health system[9]. The role of primary care identification and treatment of mental health conditions is important for special populations including older adults and low-income minority populations that are likely to go undiagnosed due to a lack of access to primary care.

In addressing how to integrate mental health and general health, the Surgeon General's 2000 Report: Integration of Mental Health Services and Primary Health Care provides a set of twelve core principles to facilitate the development and implementation of national and local programs. They include an emphasis on consumers and their families, promotion of health and overcoming disparities, basic characteristics, financial incentives for team approaches, reimbursement to support evidence-based care, collaboration/collocation, chronic illness and continuity of care, standardized quality and outcome measures, building on existing models, research and demonstrations, investment in training, and information technology[10].

## Call to Action

Mental Health America is dedicated to supporting national, state, and local efforts to integrate mental and general health care and to continued efforts to improve the quality of mental health and substance use services available in general health care settings and the quality of primary health care services available in specialty mental health care settings. Our goal is to foster the broad implementation of available research and models in real-world health delivery systems, to ensure that services are appropriate to the population being served, and to eliminate the clinical, financial, policy and organizational barriers to the integration of mental and general health care.

- The integration of mental and general health care must occur at all system levels including the federal, state, and local levels. It also requires a clear effort to overcome the clinical, financial, policy and organizational barriers to fully integrating mental and general health care.
- Many effective mental health services, especially psycho-social, recovery-oriented and rehabilitation services have not been provided in traditional medical treatment settings. It is essential that such services be provided as components of integrated treatment of mental health conditions
- The federal government should clarify the ability of primary care providers to bill for mental health services, including prevention, screening, and consultation. Medicaid should financially support care coordination and other integration models that have proven to be effective at addressing the needs of diverse populations.
- The federal government should build integration into grant programs, information technology, and policies. The private sector should share its experience with care coordination in order to help foster the growth of integration in all health systems.
- There should be a national action agenda established to foster relationships between consumers, providers, physicians, and payers to overcome the barriers that prevent broader utilization of integration models.
- States and local authorities should also develop initiatives to oversee the provision of health care and to develop community coalitions that can implement integration models that address their communities' unique needs.
- Information technology has the potential to improve the delivery of comprehensive services through improved communication and coordination. The coordination of information systems that bridge systems should promote the use of shared databases across all health service areas while maintaining patient/consumer rights and privacy. Integration also requires better coordination of quality outcome/performance measures. If the quality metrics used to measure healthcare are not aligned, efforts to establish best practices in integration will be pointless. Measurement standards should cross mental and general health and should be influenced by consumer preferences and input.
- Organizational issues that need to be addressed include training on both sides of the integration interface: Healthcare workers need to be educated on the value of addressing all health needs in an integrated way, on the recognition of health conditions, and on how to treat mental conditions and when and how to refer to community services.
- It should be an overarching goal to reduce the stigma within both provider communities to eliminate the separation of mental and general health and to overcome stereotypes about individuals with mental health conditions.
- A first step should be better utilization of screening tools in primary care settings with tools that are culturally competent and appropriate for varying literacy levels.
- Research is needed on the use of integration models with various mental health conditions and for addressing the needs of disparate populations and co-morbidities.

**Effective Period**

This policy was approved by the Mental Health America Board of Directors on October 6, 2007. It will remain in effect for five (5) years and is reviewed as required by the MHA Public Policy Committee.

**Expiration:** October 6, 2012

[1] IOM, Improving the Quality of Health Care for Mental and Substance-Use Conditions, Quality Chasm Series. Washington: National Academies Press, 2005. http://www.iom.edu/?id=30858

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[3] Ibid

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**Page last updated:** 11/07/2007

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# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.


Organization* (if applicable)_LifeLong Medical Care
Contact Person Nance Rosencranz
Address PO Box 11247, Berkeley 94712
Phone No./ Email address 510.981.4137 nrosencranz@lifelongmedical.org


**Please attach a list of all groups and organizations that contributed to this report. SEE BELOW*


Bay Area Community Services (BACS), Kent Ellsworth, Executive Director
7901 Oakport Street, Suite 3400
Oakland, CA 94621
510) 613-0324, kellsworth@bayareacs.org


*What age group does your organization serve or represent? Lifelong serves ALL AGES. BACS serves all adults. This paper focuses on older adults*

❒ Children & Youth (0-18) ❒ Transition Age Youth (14-25) ❒ Adults (18-59) Xxx Older Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

### Key Community Mental Health Needs

Xxx Disparities in Access to Mental Health Services
❒ Psycho-Social Impact of Trauma
❒ At-Risk Children, Youth and Young Adult Populations
❒ Stigma and Discrimination
❒ Suicide Risk

### Priority Populations

Xxx Underserved Cultural Populations
❒ Individuals Experiencing Onset of Serious Psychiatric Illness
❒ Children/Youth in Stressed Families
❒ Trauma-Exposed
❒ Children/Youth at Risk for School Failure
❒ Children and Youth at Risk of Juvenile Justice Involvement

For more detailed explanations of the terms above, please review the PEI Program & Expenditure Guidelines available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

# Community Report
# Prevention and Early Intervention

# Frail Elder Depression Care: A Strategy for Early Intervention
# December 14, 2007

## Executive Summary

Section I – Organizational Background

**Bay Area Community Services:** Since 1953, Bay Area Community Services (BACS) has been a leader in the development and delivery of specialized services to the elderly and adults with mental illness in the East Bay. BACS' primary goal and responsibility is to offer appropriate, cost-effective alternatives to institutionalization that improve the quality of life for those whom we serve. BACS' Mental Health Services include the Woodroe Place Crisis Residential Program, Supported Independent Living/Case Management, Employment Services, North County Senior Homeless Program and five Creative Living Centers. Our Older Adult Programs and services include Adult Day Care, Affordable Home Care, Care Management, Meals on Wheels and Senior Nutrition, Money Management Assistance, and the Oakland Senior Shuttle.

BACS serves approximately 4,000 individuals each year; 3,000 older adults and 1,000 adults 21 – 59 years of age. BACS provides meals on wheels to 1,200 homebound elderly in Oakland. Among the older adults served by BACS, these individuals have the greatest needs. Approximately 80% are minority seniors, 90% are low-income, and 95% suffer from chronic illnesses that limit their functional abilities. The majority live alone. Throughout Alameda County there are at least 3,850 frail older adults on Meals on Wheels programs each year.

**LifeLong Medical Care** (LMC) is a primary safety net health provider for low-income people in Berkeley and Oakland. We build on 30 years of history in addressing health needs:

- Our 6 community health centers provide primary care, dental care, mental health and social services, podiatry, optometry, and prevention services;
- Our Supportive Housing Program empowers formerly homeless and disabled individuals so that they can develop life skills to maintain a healthy life;
- Our Adult Day Health Center offers a daytime alternative to institutional care for frail and chronically ill adults.

LMC is proud of our participation in many community wide collaborative efforts to increase access to health care for underserved populations. LMC provides high-quality medical, mental health and social services to underserved people of all ages; creates models of care for the elderly, disabled, mentally ill and homeless; and advocates for continuous improvements in the health of our communities.

In 2007 LMC clinics provided over 108,000 healthcare visits and served over 16,000 individuals in communities dramatically impacted by health disparities. 76% of our patients are people of color, 41% are uninsured, 74% have incomes at or below 200% FPL, 31% have a diagnosed mental illness, and 16% are homeless. LifeLong's multidisciplinary staff is culturally, linguistically, and racially diverse, enabling our clinic sites to provide culturally competent care to this diverse patient population.

Section II – Data Sources

1. *Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities*, DHHS Pub. No. (SMA) 05-4018. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

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Section III – Recommendations

Priority should be given to developing and operating a **depression care program to reach and treat frail, low-income older adults who suffer from severe depression** throughout Alameda County:

Depression is among the most prevalent mental disorders of older adults, and is associated with high rates of alcohol use and suicide. Given the fact that older adults have the highest suicide rate of any age group, the need for early intervention cannot be overemphasized. Tailored and proven methods of early identification and treatment of depression among the frail older adult population are needed. Effective intervention will reduce the stigma associated with both aging and mental illness, and dispel the misperception that depression is a "normal" part of aging. The goal is to alleviate serious disparities in access to mental health services for older adults; mitigate the psycho-social impact of ongoing trauma, and reduce suicide risk

A community-based collaborative including LMC and BACS will identify, engage, and treat depression with linkage to primary care, and case management to address fundamental unmet needs of frail isolated seniors. The population of focus is frail older adults of color who have difficulty accessing traditional services and activities due to disability or other factors (and who are not able to advocate for themselves in community forums). The coordination of services to improve mental health, physical health, and the home environment will reduce self-neglect, suicide and premature institutionalization, and promote quality of life, and active engagement in the world.

A broad range of services will be made available to socially isolated individuals including mental health treatment, primary care, and case management. Participants will benefit from improved coordination among these services.

*Key Activities:*

- Depression screening of BACS and LMC clients receiving home-based services (differentiate depression from dementia using Pat Arean's model)
- Comprehensive assessment of those suffering from depression.
- Depression Care Management (IMPACT) linked to primary care
- Primary Care
- Case management/ resource coordination

Frail, low-income seniors of color are an underserved cultural population in Alameda County.

## Frail Elder Depression Care – Program Proposal

Intro

> *The number of older adults in this country is increasing rapidly, and so, too, are their needs for long-term mental health services and supports. Seven million people age 65 and older in the United States (20 percent of the older adult population) have a psychiatric illness, and that number is expected to double to 15 million in the next three decades. Older adults with serious mental illnesses receive lower quality of care and have higher mortality rates than older adults without a mental disorder. They are also three times more likely to be placed in nursing homes.* [1]

Depression is among the most prevalent mental disorders of older adults, and is associated with high rates of alcohol use and suicide. Given the fact that older adults have the highest suicide rate of any age group, the need for early intervention cannot be overemphasized. Tailored and proven methods of early identification and treatment of depression among the frail older adult population are needed. Effective intervention will reduce the stigma associated with both aging and mental illness, and dispel the misperception that depression is a "normal" part of aging.

In this project, two organizations with demonstrated expertise working with low income seniors, LifeLong Medical Care and Bay Area Community Services, will partner to screen and provide treatment for depression among frail and isolated seniors in Alameda County. By doing so, we will reduce the disparities in access to mental health services for this growing yet at-risk and underserved population.

**LifeLong Medical Care (LMC)** provides model programs for low-income elderly patients which feature an integrated physical, social and behavioral health approach. However, these services are too often inaccessible to the most frail or isolated individuals in need of care. LMC does not have resources to conduct outreach to isolated or homebound individuals, nor to provide the level of coordination needed to make patient care truly accessible to those without the ability or support needed to actively seek care or to get to appointments at the clinic. While depression screening and treatment is currently available to patients who come to LMC clinics for care, it is not accessible to those who receive LMC primary care at home.

**Bay Area Community Services (BACS)** has expertise in delivering home and community based support services for frail and isolated seniors. However, the socially isolated clients receiving home-based services such as Meals on Wheels often appear to be suffering from undiagnosed or untreated mental or physical illnesses which contribute to the self-perpetuating cycle of decline.

This community-based collaborative will identify and treat depression with linkage to primary care, and case management to address fundamental unmet needs of frail isolated seniors. The coordination of services to improve physical health, mental health and the home environment, will reduce self-neglect , suicide and premature institutionalization, and promote health, quality of life, and active engagement in the world.

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[1] *Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities,* DHHS Pub. No. (SMA) 05-4018. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

Need

> *Older adults are less likely than younger persons to self-identify mental health problems and are less likely to seek specialty mental health services.*[2]

High rates of undiagnosed and untreated depression among older adults often coincides with isolation, physical illness or frailty. Depression among essentially homebound seniors is estimated at over 40%, more than twice that of the general elder population. [Bruce ML. Psychosocial risk factors for depressive disorders in late life. *Biol Psychiatry.* Aug 1 2002;52(3):175-184.
The combination of depression and frailty, particularly for seniors who live alone, is a recipe for extreme social isolation and progressive self-neglect. The impact of mental health on physical health has been well established, and highlights the fact that depression care must be provided in order to maximize physical health and quality of life. Yet standard methods of identifying and treating depression in adults are not reaching frail elders in our community.

By joining forces, BACS and LMC can identify isolated individuals suffering from depression, and provide a truly integrated treatment program with improved access to primary care, mental health services, and other supports.

Methods

> *Evidence supports the effectiveness of Problem Solving Therapy in preventing the onset and worsening of depression. In addition, targeted outreach is effective in engaging isolated and vulnerable older adults in mental health care. Protocol-driven treatment of depression delivered by a care manager has been associated with reduced suicidal ideation*[3]

This project will screen, engage, and provide depression care management for frail older adults who have difficulty accessing traditional services and activities due to disability or other factors. A broad range of services will be made available to these socially isolated individuals including mental health treatment, primary care, and case management. Participants will benefit from improved coordination among these services.

*Key Activities:*

- Depression screening of BACS and LMC clients receiving home-based services (differentiate depression from dementia using Pat Arean's model)
- Comprehensive assessment of those suffering from depression.
- Depression Care Management (IMPACT) linked to primary care
- Primary Care
- Case management/ resource coordination

*Screening & Assessment:*
Over a one year period 1,500 BACS home-based program participants and 175 LMC patients receiving primary care in the home will receive preliminary depression screening. Participants will be screened

[2] *Substance Abuse and Mental Health Among Older Adults: The State of the Knowledge and Future Directions,* Older American Substance Abuse and Mental Health Technical Assistance Center, Rockville, Maryland, 2005
[3] *Evidence-Based Practices for Preventing Substance Abuse and Mental Health Problems in Older Adults,* Older American Substance Abuse and Mental Health Technical Assistance Center, Rockville, Maryland, 2005

in the home by BACS or LMC staff using the PHQ-9 to measure depressive symptoms. At least 42% (703) are expected to screen positive (twice the rate of current LMC patients coming to the clinic for primary care). Those who screen positive will receive a follow-up home visit with a social worker for a more comprehensive assessment to evaluate the nature of the depression and whether it is lifelong, situational, or related to medical needs, substance abuse or other factors. Suicide and Fall Risk Assessments will be conducted along with an evaluation of mobility needs, ADLs, IADLs and safety of the home environment. For BACS clients, status of an active primary care provider and current health insurance coverage will be reviewed in order to determine options for care.

*Depression Care:*
The evidence-based model of depression care management known as IMPACT (Improving Mood: Promoting Access to Collaborative Treatment for Depression) will be utilized by both BACS and LMC case managers. LMC is currently using this team-based approach for patients coming to the health center for primary care, and has found it to be highly effective. Trained social workers act as Depression Care Managers who work in coordination with the patient, primary care physician and designated psychiatrist and psychologist to develop, implement, and review a treatment plan.

Guiding the implementation of the IMPACT model is Patricia Arean, PhD, licensed clinical psychologist. Dr. Arean is an associate professor in the UCSF Department of Psychiatry, and a nationally recognized expert in the recognition and treatment of mental disorders in older adults. She has provided input on the development of this collaboration, and will serve as a consultant for this project. Dr. Arean will also provide clinical expertise to insure that services are rendered in the most culturally appropriate manner.

IMPACT services will be offered to the BACS clients and LMC patients who screen positive for depression. Approximately 20% (141) of participants who are offered services are expected to accept Depression Care Management. The remainder may elect "watchful waiting", which provides that they will be contacted periodically by a social worker, with renewed opportunities to begin Depression Care Management if they so choose.

The role of the Depression Care Manager is as follows:

1. Educate the client about depression
2. Support antidepressant therapy if/when prescribed by the primary care provider
3. Coach the client in behavioral activation and pleasant events scheduling
4. Offer short-term (6-8 session) counseling including Problem-Solving Therapy
5. Monitor depression symptoms for treatment response
6. Complete a relapse prevention plan with each patient who has improved

Depression symptoms are measured regularly using the PHQ-9, and improvement is typically made in 10-12 weeks. If the patient has not significantly improved, the treatment plan is revised. For clients receiving primary care from LMC, medications and psychiatric consultations will be made available. When BACS is providing Depression Care Management, BACS Depression Care Managers will make every effort to coordinate with the client's primary care provider. If that is not possible, the IMPACT model will be adapted to meet client needs. BACS staff will consult with Dr. Arean to facilitate this process.

*Primary Care:*
Only 33% of BACS recipients of home-based services have seen a doctor in the past year. Without medical assessment and treatment, it is impossible to decipher the root causes of depression or other

factors that may lead to the level of isolation and despair known to essentially homebound individuals. The need for primary care cannot be overstated, and is an integral part of the IMPACT model of care. Patients requiring medical attention, or electing medication to treat depression, will be referred to their current primary care provider, or to LMC if none exits. Whenever possible, the primary care provider participates in regular IMPACT team meetings to discuss patient progress and needs. If making changes to health coverage is in question, Health Insurance Counseling & Assistance Program (HICAP) assistance will be enlisted for a well-informed and unbiased review of options.

In order to accommodate new referrals to LMC for primary care and IMPACT services, LMC will increase its capacity for in-home care, from a .5 FTE provider, to a 1.0 FTE medical provider serving up to 200 homebound patients in one year. Current IMPACT experience at LMC indicates that patients who initially require IMPACT services provided in the home are subsequently able to travel to the clinic for care. This supports the notion that depression care can effectively reduce isolation and increase mobility, thereby increasing access to less costly clinic-based primary care as well as opportunities for social engagement.

*Case Management:*
Case management services will be offered to those suffering from depression based on individual need. BACS will provide case management for the clients who have an established relationship with a non-LMC primary care provider. LMC patients will be case managed by LMC in order to facilitate direct participation in the team-based model of care.

For all individuals receiving services, linkage to other programs serving isolated individuals (i.e., Senior Center without Walls) will be facilitated in order to address needs that may contribute to isolation and depression. Case managers will help facilitate transportation for participants to improve access to activities of interest, as well as clinic- based primary care and mental health services.

BACS will provide non-clinical support for all participants to help create a home environment that is safer, more stimulating and less isolating. This will include tangible services such as installation of grab bars or home clean-up.

When there is an indication of substance abuse or self-neglect concurrent with depression, appropriate referrals to Adult Protective Services, Adult Day Health Care, or other services will be made, with follow-up and coordination with the IMPACT team.

Evaluation

Pre and post data will be evaluated to determine outcomes using tracking methods that are an integral part of the IMPACT program. Results of each screening, depression score and contact made are logged using a database module designed specifically for this purpose. These tools will allow for careful monitoring of client status, needed follow-up, and outcomes. The goal of achieving lowered depression scores among IMPACT clients will be clearly documented and reported.

Trends will be analyzed to determine the efficacy and best practices of IMPACT services in a setting such as BACS, where primary care services are not as fully integrated into the care team, as well as for LMC patients receiving primary care at home.

Summary of Objectives & Outcomes

*Population of Focus*

- *Frail and/or isolated older adults*
- *Recipients of home-based services from BACS and/or LMC*

**The Client:**

| Objectives | → | Outcome |
|---|---|---|
| Screen 1,675 individuals for depression | | Improve Mental & Physical Health and Quality of Life |
| Provide in-home Depression Care Management for 141 individuals | | |

**The System:**

| Objectives | → | Outcome |
|---|---|---|
| Develop infrastructure to support integrated mental health, primary care and case management services | | Institutionalize IMPACT depression screening and treatment for recipients of home-based services |
| Adapt IMPACT model of care for community-based service provider (BACS) | | |

# Mental Health Services Act
## Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to mhsa@acbhcs.org no later than December 14, 2007.


Organization* (if applicable): Crisis Support Services of Alameda County
Contact Per son: Nancy A. Salamy, MFT Executive Director
Address: P. O. Box 3120 Oakland, CA 94609
Phone No./ Email address: (510) 420-2467 nsalamy@crisissupport.org


**Please attach a list of all groups and organizations that contributed to this report.*

*What age group does your organization serve or represent?*

XChildren & Youth (0-18) XTransition Age Youth (14-25) XAdults (18-59) XOlder Adults (60+)

*Under each category, choose the item your report PRIMARILY addresses:*

Key Community Mental Health Needs

- ❒ Disparities in Access to Mental Health Services
- ❒ Psycho-Social Impact of Trauma
- ❒ At-Risk Children, Youth and Young Adult Populations
- ❒ Stigma and Discrimination
- X Suicide Risk

Priority Populations

- ❒ Underserved Cultural Populations
- ❒ Individuals Experiencing Onset of Serious Psychiatric Illness
- X Children/Youth in Stressed Families
- X Trauma-Exposed
- X Children/Youth at Risk for School Failure
- X Children and Youth at Risk of Juvenile Justice Involvement

**Crisis Support Services of Alameda County**
**P.O. Box 3120**
**Oakland, CA 94609**

## Prevention & Early Intervention Executive Summary

**Section 1–Organizational Background:** Crisis Support Services of Alameda County (CSS) began in 1966 as a suicide prevention and crisis line. Since then, we have grown to provide a variety of mental health services to a wide range of persons in varying degrees of crisis. Our primary program is our 24 -hour telephone crisis line. Over the course of a year we respond to more than 40,000 calls from Alameda County residents who need help. Many of our callers suffer from serious mental illness and are at an extreme risk for suicide. Our crisis line is a lifeline for many of our most vulnerable residents. In addition to the crisis line, we provide the following services: (a) counseling and support to isolated, homebound seniors and on-site geriatric mental health services (b) grief counseling and mental health crisis services for community members who have experienced a trauma (e.g., grief and loss to homicide, suicide, accidental death and complicated bereavement); (c) school-based counseling services for at-risk youth; and (d) a comprehensive suicide prevention and education program which targets both youth and adults.

CSS is certified by the American Association of Suicidology. We are members of the National Suicide Prevention LifeLine (sponsored by SAMSHA); the Alameda County Council of Mental Health Agencies and Bay Area and Crisis Intervention Alliance. CSS is made up of over 20 dedicated, professional staff, and over 80 volunteers who include licensed mental health clinicians, mental health professionals in training and community volunteers. Our unique and highly regarded training program utilizes instructive seminars, one-on-one-experiential training, professional consultation and comprehensive printed materials maintaining "best-practice" standards.

Since Alameda County Behavioral Health Care Services started its toll-free ACCESS number in 1997 as part of the State of California's Medi-Cal consolidation, CSS has provided after hours telephone coverage for the ACCESS number. CSS provides crisis screening, information and referral, handling all urgent behavioral health needs for Alameda County residents (including all Medi-Cal beneficiaries) who call the toll-free number outside of regular business hours.

**Section 11- Data Sources:**
According to the American Association of Suicidology, in 2005, 32, 637 people in the US completed suicide: 4,500 are young people and 5,400 are seniors. Every 16.1 minute someone in the US dies from suicide; older adults die by suicide every 1 hour and 37.3 minutes; and a young person dies by suicide every 2 hours and 4.8 minutes. Suicide is the 11th ranking cause of death in the US and 3rd for young people (homicide ranks 15th). There are 25 attempts in the adult population for each completion and in the adolescent population there are 100-200 attempts for each suicide completion. CSS has responded to 1.3 million calls on the crisis line since 1966. 2,534 of those callers ended up requiring a hospitalization. That is less than 1% of callers requiring emergency procedures. Research demonstrates that crisis lines are effective and can reduce distress and suicidality; “An Evaluation of Crisis Hotline Outcomes” Kalafat, Gould, Munfakh and Kleinman. Published in “Suicide and Life-Threatening Behavior:” June, 2007. CSS adheres to evidence-informed risk assessment standards that may

be the most thorough and comprehensive in the field of behavioral health (Standards published by the National Suicide Prevention LifeLine).

**Section 111 – Recommendations:**
**Crisis Line:**
**Language Capacity and Cultural Competence:** We currently utilize the AT&T language line for non-English language calls. An important goal of the agency is to expand the capacity of our services to provide "live" language lines in Spanish and Asian languages during specified hours.
**Mental Health Awareness:** Many people in crisis may not be aware of our vital 24 hour crisis line. CSS clinical staff and mental health interns routinely provide on-site individual counseling, support groups and community debriefings to suicide survivors. Survivors report that their loved ones were not aware of the services provided by CSS. Tragically, those individuals who desperately needed our services did not utilize our crisis line, resulting in a preventable death. The ripple effect of suicide is devastating to families and community members resulting in increased risk of job loss, academic failure, depression, substance abuse, violence and suicide. Currently we advertise our agency information in the AT&T yellow and white pages, local media, academic institutions and the internet. Clearly increased funding is needed in order to better advertise our crisis line number. We would like this advertising to be culturally competent and language appropriate in order to reach all members of our community.

**Grief Counseling and Mental Health Crisis Services:**
**Expand School-Based Counseling:** In response to a need in the community, CSS provides counseling to 100 students each year serving elementary through high school age students. Each year, there are requests from schools throughout the county requesting crisis counseling for students in the aftermath of a traumatic death. Our ability to respond to this need is limited. For example, there are currently 33 students on a waiting list just at Hayward High School. In order to meet the need of young people at risk, CSS needs additional funding.

**Drop-In Stress and Crisis Counseling:** The Oakland Truancy Center requested that we provide drop-in stress and crisis counseling for youth at their facility. Many of the youth served by the truancy center are not receiving much needed crisis intervention and mental health services. CSS has expertise in working with drop- in counseling services both in our school based program and through our 10 year long contract with the Oakland Private Industry Council. CSS developed a creative and highly successful model for working with underserved adults utilizing the one stop career center that was operated by the Oakland Private Industry Council. By providing drop-in mental health and early intervention services on-site at the Oakland Truancy Center, CSS's expertise in this area would certainly benefit more at risk youth in the community.

**Transitional Age Youth Suicide Attempter's Group:** According to the Centers for Disease Control and Prevention, young people, age 15-24 are the third highest group in the US for suicide. There are approximately 5000 young people that die each year in the US to suicide. 100-200 attempts take place for each completion. Many students struggle with suicidal feelings isolation and lack constructive coping skills. In keeping with our mission, CSS would like to provide a therapy group for college age students who have made a suicide attempt. Individuals who have made an attempt are 40 times more likely to die by suicide than the general population. In addition to the clear need of

youth at risk in our community, research indicates that therapy groups for youth reduce suicide attempts and other destructive behavior.

**Older Adult Services:**

**Expand In-Home and On-Site Older Counseling Services:** Presently, elders 65+ make up 1/8 or 12.6% of the population and account for 1 in every 5 suicides or 20%. Each stage of life presents us with challenges as well as opportunities. For older adults, common obstacles to life satisfaction and happiness include declining health, social isolation, grief, loss, family discord and financial uncertainty. In addition, loneliness and isolation place seniors at a high risk for emotional distress, physical discomfort, substance abuse, depression, despair and suicide.

Like many of us, seniors are often reluctant to seek treatment or they do not know where to turn for help. Seniors who are faced with any number of challenges may incorrectly assume that depression is an unavoidable consequence of growing old. The truth is that depression is a treatable condition, and untreated depression can worsen the course of other illnesses and can otherwise undermine the desire to improve one's situation.

CSS's expertise in the area of geriatric mental health has developed with the Senior In-Home Counseling Program which began in 1993. This unique in-home program provides counseling and emotional support to isolated, homebound seniors who would not otherwise have access to mental health services. In 2006, we expanded our senior services by adding an on-site counseling program to accommodate the request for services from older clients who did not qualify as home bound and are able to come in to our North Oakland office. All clients are assessed using Dr. David Burn's Mood Survey at the onset of treatment and every 10 sessions thereafter. The survey measures for depression, anxiety, anger, panic, and suicidality.

As a member and partner of the Senior Service Coalition of Alameda County, CSS is dedicated to providing geriatric mental health services, crisis intervention, suicide prevention and support services to the elderly on our 24 hour crisis line and through our direct senior counseling programs.

Our clients are typically low income, culturally diverse and facing a multitude of challenges. The need for in-home mental health services is very high and we usually have a waiting list. Contrary to public opinion or the common assumption that old people can not, or will not change, our elder clients make good use of our counseling services which enable them to live more productively and independently in their own homes. We would like to expand these services for our most at-risk elders.

**Suicide Prevention Education and Awareness:**

**Expand Community Education:** Research and experience have taught us that education and openness about suicide help to prevent self-destructive behavior. Children who are able to openly share their feelings and thoughts of suicide are often less likely to act on their suicidal feelings and more likely to find resources.
Our Community Education Department is committed to this very serious issue. We have been working to increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide for over 20 years. We reach out in two ways: Our Teens for Life program goes out to middle and high schools to conduct suicide prevention education to youth in the classroom. Correspondingly, our adult education program

provides high quality in-service trainings to teachers and school staff that will help them identify and reach out to a student in distress. CSS provides education on depression and suicide prevention to approximately 12,000 young people in middle and high schools each year. There are 157 middle and high schools in Alameda County. CSS is in an average between 45 and 50 schools each year.

Our curriculum is interactive and designed to prevent suicide in young people by giving them the tools they need to ask for help when feeling hopeless. When we talk to teens in schools, we ask “How many of you know someone who has tried—or succeeded at suicide? It may be hard to believe, but these days 50% of the teens raise their hands. More teenagers die from suicide than from cancer, heart disease, AIDS, birth defects, stroke pneumonia, influenza and chronic lung disease combined. According to the Centers for Disease Control and Prevention, Youth Behavior Risk Survey: Young people grades 9-12 reported that 17% seriously thought about suicide; 13% made a suicide plan and 8% made at least one attempt in the previous 12 months.

Our experience in the classroom shows that when suicidal teens are struggling with depression, their lack of knowledge can prevent them from finding helpful resources. They may have no way of knowing that suicidal crises tend to be brief. However, when suicidal behaviors are detected early and interventions are made, lives can be saved! We would like to be able to be in all schools -- and make certain that at least once while in school, every student in Alameda County receives training on suicide prevention. We would like this to include those youth who are in foster care or the Juvenile Justice system.

This year we plan to send our curriculum and internal outcome measures (pre/post test evaluation scores) to the Best Practices Registry (BPR) which evaluates suicide prevention programs and practices. The BPR works in collaboration with the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention. The purpose of the BPR is to identify, review and disseminate information about best practices that address specific objectives to the *National Strategy for suicide Prevention.* Based on our many years of experience in the classroom, our outcome measures, and the positive evaluations from teachers and counselors, we are eager to receive feedback on our suicide prevention curriculum.

**Language Capacity:** We use the “gatekeeper” model of providing trainings in suicide prevention for teachers, parents and community-based organizations. We would like to provide this training in other threshold languages. We provided our first mono-lingual Spanish training to "Latino Best Now." We also would like to enter those hard to reach communities to bring education and information about suicide prevention resources to parents and youth. We also provide in-service trainings on suicide assessment and intervention for mental health practitioners and interns working with youth and adults.

# DRAFT
# Stigma and Discrimination Reduction Program

**Overall Goal:** To decrease stigma and discrimination of and promote community inclusion for people with mental disabilities through the contact method of a consumer operated program. The contact method of changing stigma utilizes direct contact with people with mental disabilities as a change agent.

**Need Statement:** Consumers have indicated, throughout the years, the high price that discrimination and stigma exacts on their lives and thus the importance of reducing them.

In 1987 a groundbreaking research project developed and conducted by consumers, The Well Being Project: Mental Health Clients Speak for Themselves, surveyed over 500 mental health clients, family members , and mental health professionals and caregivers. The survey found that "more than half of the clients interviewed felt that they had been discriminated against because of psychiatric labeling." [i]

In 1998, the California Network of Mental Health Clients (CNMHC) did focus groups throughout California to determine how mental health clients define "client culture." Clients self identified as being victims of discrimination and stereotyping more than any other client culture characteristic. In fact, the experience of discrimination was the most repeated characteristic of client culture. [ii]

In October, 2007 clients - again - conveyed the devastating effects stigma and discrimination have on their lives. In filling out a Social Inclusion (Discrimination and Stigma Reduction) Proposal Survey (reference) at the "Breaking the Ties that Bind: Challenging Stigma and Discrimination" Conference, they proposed what the anti-discrimination and stigma message should be. In these anti-discrimination and stigma messages, they described the effects of discrimination and stigma on their lives. They emphasized the inequality they experience, in value, in access, and in relationships. They also highlighted the barriers to recovery and hope, caring and empathy, and social inclusion that discrimination and stigma generate.

The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America states that "Stigma is a pervasive barrier to understanding the gravity of mental illnesses and the importance of mental health." [iii] Clients have been saying this for many years.

| **Strategy** | **Target Population Served** | **Summary of Proposed Activities** | **Program models and research resources for proposed activities** |
|---|---|---|---|
| 1. Provide outreach, education and training to decrease negative stereotypes about people with mental | Target key groups that have power in lives of people with | • Establish an Outreach, Education and Training Program;<br>• Train trainers to serve on Speakers/Trainers | Stamp Out Stigma – San Mateo County; |

| | | | |
|---|---|---|---|
| disabilities and thus prejudice and discrimination, thereby promoting equal access to the workplace, schools, housing, and health system. Contact, education, and protest methods will be used, appropriate to the situation. [iv] | mental disabilities:<br><br>Serves people with mental disabilities of all ages and special populations | Bureau;<br>• Target specific power groups: faith based communities; schools; landlords; employers; policy makers; health and mental health systems; criminal justice system. Begin with targeting 1 – 3 of these power groups.<br>• Create an Action Committee composed of consumers, members of the targeted group, as well as others;<br>• Develop an Action Plan specifically tailored to the targeted group. Development of the Action Plan may include a survey of the targeted group;<br>• Evaluate the effectiveness of the activities by pre and post surveys;<br>• Include education on disability rights in curriculums;<br>• Gather from existing sources (or develop) educational materials on disability rights, including a resource guide;<br>• Collaborate with Disability Rights organizations so that their scope of advocacy is inclusive of mental disabilities;<br>• Hold an annual Conference that targets either a power group or a stigma and discrimination issue. | Public Awareness Committee, Alameda County Mental Health Advisory Commission.<br><br>Patrick Corrigen: "Target –Specific Stigma Change: A Strategy for Impacting Mental Illness Stigma", Psychiatric Rehabilitation Journal, Fall 2004. |

| | | | |
|---|---|---|---|
| 2. Combat the pervasive stigmatizing of people with mental disabilities in the media, through exposing negative stereotypes and promoting positive images of people with mental disabilities. | Target group is Media.<br><br>Serves people with mental disabilities of all ages and special populations | • Develop a Media project;<br>• Develop the stigma and discrimination reduction message(s) with an Advisory Committee;<br>• Develop a Media Watch initiative that will identify and respond immediately to negative images of people with mental disabilities;<br>• Produce a Web Site for the Stigma and Discrimination reduction program, including fact sheets, articles, resources;<br>• Continue Alameda County Mental health Matters, a public access TV program produced by consumers on mental health issues;<br>• Develop TV, radio, and newsprint opportunities to promote positive messages and images about people with mental disabilities;<br>• Develop DVD's of consumers' stories of recovery as well as other educational materials;<br>• Influence the county's Network of Care to include consumer perspectives and programs, with an emphasis on recovery. | National Stigma Clearinghouse, Jean Arnold, http://www.stigmanet.org/<br><br>SAMHSA's Resource Center to Address Discrimination and Stigma: www.adscenter.org |
| 3. Enhance personal empowerment and spirituality to combat the internalized stigma that demoralizes | Target group is people with mental disabilities of all ages | • Develop a Personal Empowerment and Spirituality Project;<br>• Expand WRAP programs to 4 threshold | PEERS/<br>Copeland Center for Wellness and Recovery.<br><br>Paula Comenelli, Listening |

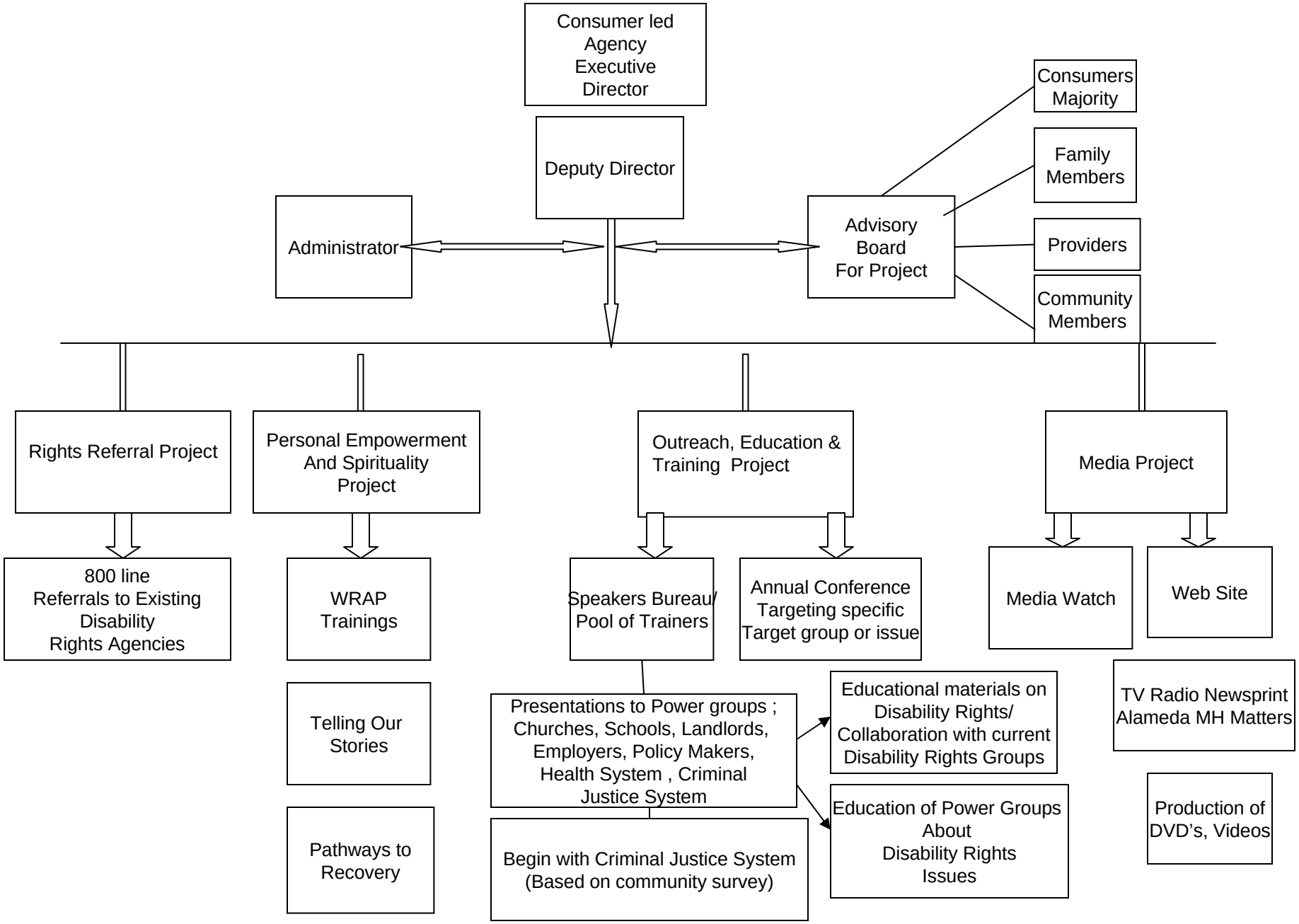
| | | | |
|---|---|---|---|
| people with mental disabilities and inhibits their recovery. | and special populations. | languages in Alameda County, to special population groups including young TAY, older adults, and LBGQ populations, and to the 2 county regions who currently do not have WRAP trainings;<br>• Provide Telling Our Stories trainings;<br>• Provide Pathways to recovery trainings.<br>• Evaluate the trainings' influence on personal empowerment by existing empowerment measurement tools. | Well<br><br>Pathways to Recovery: A Strengths Recovery Self-Help Workbook,<br>Priscilla Ridgeway, et al. |
| 4. Address practices of external discrimination that impedes integration into the community of people with mental disabilities. | Target group is people with mental disabilities of all ages and special populations. | • Develop a Rights Referral project;<br>• Establish an 800 telephone line that consumers can call when they experience discrimination. Phone advocates will provide referrals to existing disability rights organizations as well as document the act of discrimination, looking for patterns of systemic discrimination. | |

[i] People Say I'm Crazy, The Well Being Project, Jean Campbell and Ron Schraiber co directors, The California Network of Mental Health Clients under contract to The California Department of Mental health, Office of Prevention, 1989, p.57.

[ii] Client Culture Training/Focus Groups Project Report, a project of the California Network of Mental health Clients, funded by the California Department of Mental Health, 1998, Executive Summary, pp. 1 -5.

[iii] The President's New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America, Final Report, July 2003. p.20.

[iv] Patrick Corrigen identifies approaches to changing public stigma into three processes: protest, education, and contact. "Protest strategies highlight the injustice of specific stigmas and lead to a moral appeal for people to stop thinking that way. --- Adult education strategies has largely focused on replacing the emotionally charged myths of mental illness with facts that counter the myths. --- ." Contact strategies involve direct contact with people with mental disabilities as the essence of the process. Target-Specific Stigma Change: A Strategy for Impacting mental Illness Stigma, Psychiatric Rehabilitation Journal, Fall, 2004.


Consumer led Agency Executive Director
Deputy Director
Administrator
Advisory Board For Project
Consumers Majority
Family Members
Providers
Community Members
Rights Referral Project
Personal Empowerment And Spirituality Project
Outreach, Education & Training Project
Media Project
800 line Referrals to Existing Disability Rights Agencies
WRAP Trainings
Telling Our Stories
Pathways to Recovery
Speakers Bureau/ Pool of Trainers
Annual Conference Targeting specific Target group or issue
Presentations to Power groups ; Churches, Schools, Landlords, Employers, Policy Makers, Health System , Criminal Justice System
Begin with Criminal Justice System (Based on community survey)
Educational materials on Disability Rights/ Collaboration with current Disability Rights Groups
Education of Power Groups About Disability Rights Issues
Media Watch
Web Site
TV Radio Newsprint Alameda MH Matters
Production of DVD's, Videos